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Victim Support Registered Charity number: 298028

THE INTERNATIONAL CENTRE
RESEARCHING CHILD SEXUAL EXPLOITATION,
VIOLENCE AND TRAFFICKING



RESPONDING SENSITIVELY TO SURVIVORS OF CHILD SEXUAL ABUSE

An evidence review

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**VICTIM
SUPPORT**

APRIL 2016



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EXECUTIVE SUMMARY

This report summarises what the evidence tells us about the characteristics of adults who were sexually abused as children and how to most effectively support them.

Many adults in our society have been sexually abused as children. A national UK survey in 2011 found that 24% of 18 to 24 year olds said they had been sexually abused when they were younger (both contact and non-contact abuse).¹

The effects of childhood sexual abuse are not always obvious

The effects of childhood sexual abuse (CSA) are not always obvious, either during childhood or in adulthood. There is variation between individuals, both in terms of when problems emerge as well as what those difficulties are. CSA is associated with increased risk of depression, anxiety, eating disorders, post-traumatic stress disorder, sleep disorders and suicide attempts. It is also associated with a range of health problems as well as difficulties in building positive relationships. Individuals who were sexually abused in childhood are also at a higher risk of being revictimised compared to those with no CSA history.

Recovery can be a long process that happens gradually. Recovery is not necessarily a smooth linear process. Sometimes there can be negative turning

points (e.g. new life stressors) which can lead to a temporary loss of adaptive functioning. Positive turning points can significantly accelerate the rate of progress.

The key processes of recovering are eliminating or learning to manage the unpleasant thoughts and emotions, making sense out of what has happened and moving forward with a new enthusiasm for life. Although stages of recovery have been identified, the process is unique for each individual.

There is a difference between how resilient individuals cope after trauma and how other individuals who use adaptive coping strategies improve over time. Some individuals will be able to return to similar levels of wellbeing as those experienced before the trauma. Some people may even show post-traumatic growth and show better functioning than before the trauma.

We examined how best to provide support to clients who may have experienced childhood sexual abuse. We identified two sets of delivery principles for working with

1. Provide a safe place for the client Ensure client empowerment and collaboration	5. Have a broad knowledge of trauma theory and provide the client with psycho-education
2. Communicate and sustain hope and respect	6. Teach clients adaptive coping strategies (i.e. teach clients self-care, distress tolerance strategies and arousal reduction strategies)
3. Facilitate disclosure without overwhelming the client Be familiar with a number of different therapeutic tools and models	7. Teach clients to monitor their thoughts and responses
4. View symptoms as adaptations	8. Teach clients interpersonal and assertiveness skills.

Table 1 – Delivery principles for working with adult survivors

with clients. Table 1 shows the delivery principles for working with adult survivors of childhood sexual abuse developed by a team in Australia.

We also identified a set of principles for sensitive practice which can be used with all clients, irrespective of whether they have disclosed a history of sexual abuse. These were developed by a team in Canada and are shown in the Umbrella of Safety in Figure 1.

In the report we provide practical suggestions on handling disclosure and supporting clients. These include how to create a supportive, engaging environment, and working with some of the challenges that these clients experience in terms of engaging with and benefitting from services.

Supporting the client to feel safe and in control of what happens to them is key to success. Training and providing ongoing support to practitioners is also important.

Therapy needs to be adapted to the client, rather than expecting the client to adapt to the therapy. This is easiest when practitioners are trained in several different treatment approaches to allow tailoring to the needs and preferences of the client.

The practitioner also needs to understand how the abuse fits with the client’s ‘world-view’ or cultural perspective and tailor the support offered in light of these individual differences.

It can be useful to provide accurate information to clients about the nature of trauma and its effects, and work with them to integrate what they have learnt into their overall perspective.

Supporting the client to feel safe and in control of what happens to them is key to success

Clients should be taught adaptive coping strategies such as self-care, distress tolerance strategies and arousal reduction strategies. It is not enough to help survivors get rid of maladaptive or poor coping strategies – these must be replaced with positive and healthier ways of coping.

Approaches which involve monitoring thoughts and responses and work to change emotions, thoughts and behaviours can be particularly effective (even if they are non-trauma focused). It can also be useful to teach clients interpersonal and assertiveness skills.

Clear referral pathways should be established so survivors can receive other more intensive therapeutic supports if they

need and want them. The interventions that have been shown to be most effective tend to use cognitive-behavioural therapy, EMDR or mindfulness approaches. Both trauma focused, and non-trauma focused interventions can help clients. Group approaches can be effective, but they are most effective if combined with individual support. They need to be delivered by experienced professionals who ideally can work across a number of models to provide choice and flexibility to the client.

Figure 1 – Umbrella of safety





OUTLINE OF APPROACH

An evidence assessment was undertaken to source key pieces of robust evidence.

**A meta-analysis is a robust way of examining what all the available published and unpublished evidence on a topic tells us using a standardised approach*

It was beyond the resources of the project to undertake a full meta-analysis* or systematic review of all the areas identified. Doing an evidence assessment involves being pragmatic about sourcing quality evidence that should be representative of the larger body of evidence. Systematic reviews and meta-analyses were examined, as well as robust pieces of qualitative research.

The report is laid out in a number of sections. In the first section, the outcomes that are most often associated with child sexual abuse (CSA) are outlined. Not all individuals show the same outcomes, so an overview is provided of factors which influence risk and resilience.

In the second section, the evidence around what constitutes effective practice with adult survivors of CSA is described. This includes principles of sensitive delivery as well as the evidence base for different therapeutic interventions.

In the final section a series of recommendations for developing service delivery approaches is outlined.



POTENTIAL OUTCOMES

Involvement of a child in sexual activity that he or she does not fully comprehend and cannot give consent

Outcomes associated with Childhood Sexual Abuse

Child sexual abuse (CSA) is defined by the World Health Organisation² (WHO) as:

“the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person. This may include but is not limited to:

- *the inducement or coercion of a child to engage in any unlawful sexual activity*
- *the exploitative use of a child in prostitution or other unlawful sexual practices*
- *the exploitative use of children in pornographic performance and materials.”*

Other definitions of CSA exist, but most agree that it typically includes unwanted and inappropriate sexual solicitation of, or exposure to, a child by an older person; genital touching or fondling; or penetration in terms of oral, anal or vaginal intercourse or attempted intercourse. As shown in Figure 1, it can vary along a number of dimensions including frequency, duration, age at onset, and relationship of victim to perpetrator. CSA is often broken down into three main types of abuse.³

- non-contact abuse which includes a range of acts and includes inappropriate sexual solicitation or indecent exposure.
- contact abuse, which includes touching or fondling,
- intercourse, which includes oral, anal or vaginal intercourse.

In the UK, two important prevalence studies have been carried out over the last 15 years. The first, undertaken in 2000⁴, reported that 11% of young people aged 18 to 24

had experienced contact sexual abuse in their lifetime. A second study undertaken in 2011⁵ found that 12.5% of 18 to 24 year olds reported that they had experienced contact CSA under the age of 18 (perpetrated by any adult or peer). When the definition of CSA was broadened to include both contact and non-contact sexual abuse (perpetrated by either an adult or a peer),

24% of 18 to 24 year olds reported that they had experienced CSA. The effects of Childhood sexual abuse (CSA) are not always obvious, either during childhood or in adulthood. There is variation between individuals, both in terms of when problems emerge as well as what those difficulties are⁶. Figure 3 shows when issues can arise.

The effects of Childhood sexual abuse are not always obvious

Figure 2 – Dimensions of variation in child sexual abuse

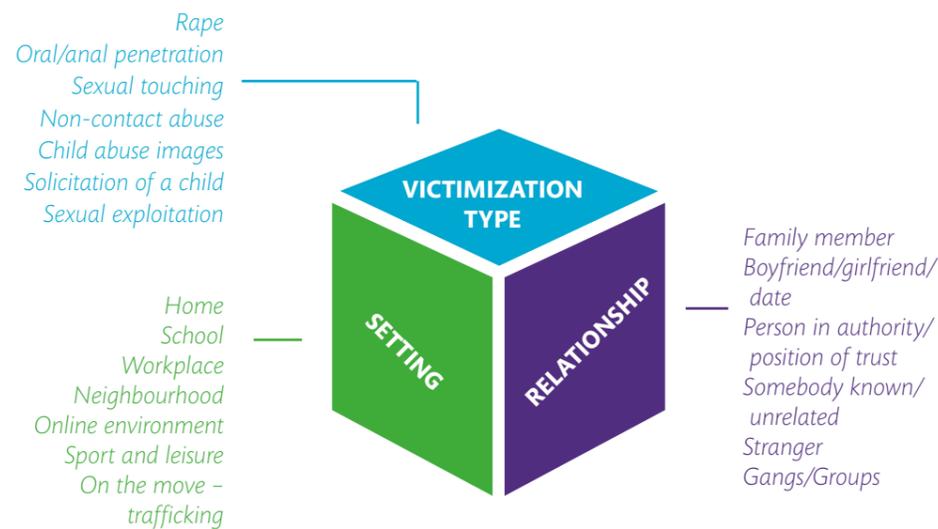


Figure 3 – Outcomes at different stages amongst survivors of child sexual abuse (CSA)

<p>Childhood</p> <p>75%-90% of known victims of CSA are estimated to report psychological difficulties during childhood. Others estimate that up to half of all victims may show no symptoms</p>	<p>Adolescence</p> <p>Effects may only start to emerge during adolescence when individuals start their own consensual relationships. These may include impaired sense of self, social withdrawal, PTSD (sometimes misdiagnosed as Attention Deficit Disorder), poor performance in school and development of anxiety disorders or phobias</p>	<p>Adulthood</p> <p>Not all survivors of abuse show poor outcomes as adults. CSA is associated with increased risk for anxiety disorder, depression, eating disorders, PTSD, sleep disorders and suicide attempts. This increased risk occurs irrespective of the victim's sex or age at which abuse occurred. Adult depression, eating disorders and PTSD are most likely amongst those who were raped as children.</p>
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Many factors can influence whether an individual will show problems in later life. The relationship is not one of simple cause and effect. Outcomes may be influenced by a range of factors including⁷:

- the age of the victim when the abuse occurred
- frequency of the abuse
- the duration (from when the abuse first occurred to when it last occurred)
- the relationship with the perpetrator
- the type of abuse (penetrative, non-penetrative etc.).

Many children who are abused experience more than one form of maltreatment. In addition to CSA, some will also experience physical abuse, emotional abuse or neglect. They may experience other risk factors such as parental separation, or living with disadvantage or poverty. Additionally, some children's experience of abuse may extend into domains outside of their family and they may experience other forms of victimisation in their community and school settings (also known as poly victimisation). Consequently it can be difficult to disentangle the unique effects of CSA since all of these factors may increase the risk of poorer outcomes⁸.

Some of the most common problems reported amongst adult survivors of childhood sexual abuse are briefly outlined below. Many of these adverse outcomes are experienced by men and women. Men, however, are more likely than women to experience stigma and fear that they will themselves become perpetrators of abuse, confusion over their sexual identity and difficulty in constructing their gender-identity (e.g. expressions of masculinity).

Mental health Issues

Not everyone who has experienced child sexual abuse shows adverse psychological consequences. The range and severity of reported problems vary amongst different people. It is estimated that 10% to 53% of CSA survivors show few, if any, symptoms in adulthood⁹. A recent meta-analysis by

Chen et al. (2010) examined all the available evidence for sexual abuse and a lifetime diagnosis of psychiatric disorders. They found that there was a strong, consistent link between sexual abuse and the following mental health issues:

- anxiety disorder
- depression
- eating disorders
- post-traumatic stress disorder
- sleep disorders
- suicide attempts.

Individuals who had experienced CSA were more likely to experience these problems later in life, irrespective of whether they were male or female, or how old they were when the abuse occurred. There was a higher risk of experiencing depression, eating disorders, and PTSD amongst those who had been raped as children. The review did not find a significant association between childhood sexual abuse and a diagnosis of schizophrenia or somatoform disorders, and there was not enough evidence to examine bipolar disorder or obsessive-compulsive disorder.

Dissociative identity disorder (DID) (also known as Multiple Personality Disorder) is the most complex dissociative disorder and occurs when someone shows a severe change in identity. Many people who experience DID were sexually abused as children, and it is thought that some individuals use dissociation to protect themselves from the trauma¹⁰. Not all individuals, however, who have been sexually abused as children will develop DID. It is most likely to occur when there is an abuse history, no consistent comfort and support from a parent or other family members and the child had to be emotionally self-sufficient¹¹.

Physical health issues

CSA is associated with poorer physical health in adulthood, although once again the effects vary between individuals and not everyone shows the same outcomes.

A meta-analysis by Irish et al. (2010)¹² showed that adult survivors were more likely to have problems with physical health symptoms such as:

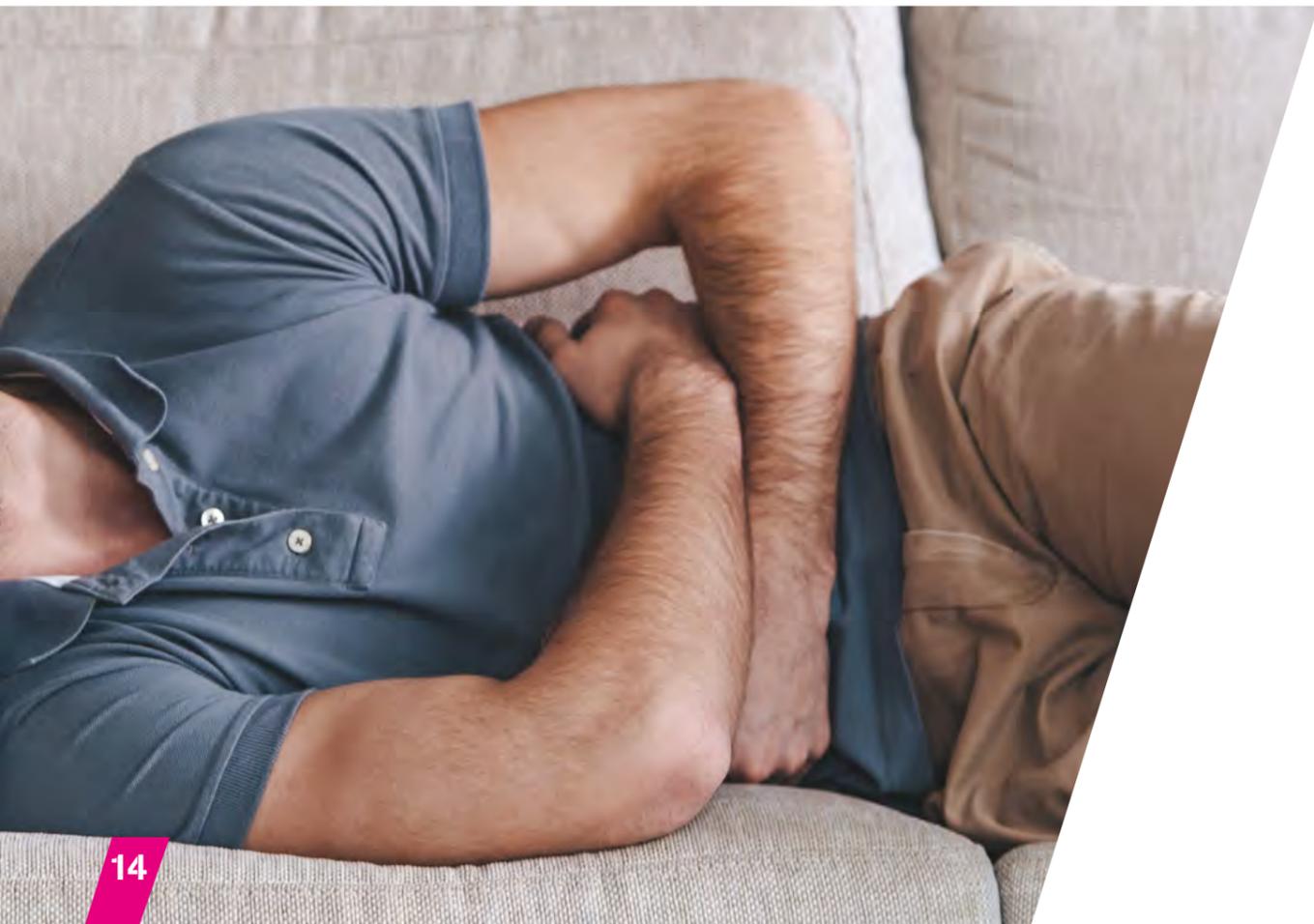
- poorer general health and having more negative perceptions of their overall physical health
- gastrointestinal problems such as irritable bowel syndrome
- gynaecological symptoms such as chronic pelvic pain
- pain such as headaches, backaches, muscle aches and joint pain
- cardiopulmonary symptoms such as chest pain, shortness of breath, irregular heartbeat, ischemic heart disease and overall poorer cardiopulmonary health
- obesity.

Some adult retrospective studies also find that survivors of CSA more frequently use health services than those with no abuse histories. Other studies, however, have shown that some survivors may avoid all contact with health professionals.¹³

Maladaptive behaviours

Survivors of CSA have been found to be at greater risk of risk-taking and unhealthy behaviour including:

- alcohol and other substance abuse including nicotine dependency.¹⁴ Some survivors use substances as a coping mechanism since alcohol and drugs can have a numbing effect on hyper-arousal PTSD symptoms¹⁵
- risky and sexualised behaviours (most pronounced in younger children and immediately after the abuse, but this may extend into adulthood)¹⁶
- increased arrest rates for both women and men for sex crimes such as sex trading (in exchange for money, drugs or shelter)¹⁷
- fear and avoidance of dentists¹⁸
- Self-blame.



Relationships

At its core, CSA involves a fundamental breach of trust. Perhaps unsurprisingly CSA is associated with problems in forming and maintaining relationships later in life. Survivors often experience difficulties in¹⁹:

- intimacy
- sexual relationships and sexuality
- risky sexual behaviour
- becoming a parent and parenting. Childbirth and motherhood can trigger emotional distress and lack of confidence and self-esteem
- adjustment problems
- teenage pregnancy (women survivors of CSA are more than twice as likely to experience teenage pregnancy)
- hostility
- becoming a victim of domestic violence.

Sexual identity

Although different studies have examined whether there is any potential association between CSA and sexual identity, there are many methodological problems with the evidence. It is difficult to draw firm conclusions and determine causality. Studies found some evidence that:

- Higher proportions of people with same sex orientation report childhood abuse and the relationship may be stronger for men²⁰. Proposed theories include that CSA may cause people to 'become' gay or lesbian; that CSA leads to confusion over sexuality and therefore greater experimentation with both same sex and opposite sex relationships; or that children who experience CSA are actually vulnerable to it because their sexual preferences pre-dated their abuse (therefore they were targeted because of experimentation behaviours or gender non-conforming behaviours).²¹ There is not enough robust evidence to decide which of these explanations (if any) is true.

- Men in particular may struggle with their sexual victimisation in relation to broader masculine norms²².

Sexual revictimisation

Survivors of CSA are more likely than other people to experience another sexual assault or repeat victimisation²³:

- it is estimated that two-thirds of CSA survivors experience revictimisation at some point in their adolescent or adult lives²⁴
- women who reported CSA may be more than 4 times more likely to report a sexual assault in adulthood²⁵
- increased risk of sexual exploitation²⁶
- sexual revictimisation is experienced equally by both men and women²⁷
- some research suggests that women who were sexually abused as children by a family member may be most likely to experience revictimisation²⁸
- female survivors of CSA are also most likely to be revictimised by an intimate partner²⁹.

Specific risk factors have been identified for sexual revictimisation. These relate to both the impacts of trauma on the individual and the individual's own coping strategies. For example:

- adult survivors who show either post-traumatic stress disorder or dissociation experience higher rates of revictimisation. Dissociation may compromise the individual's ability to react defensively when confronted with an unexpected sexual encounter³⁰
- women with a moderate to severe history of CSA often show high levels of internalised shame. This may influence how they feel about their self-worth and lead to an increased risk³¹
- Individuals who withdraw or distance themselves from others as a coping mechanism may leave themselves isolated and vulnerable to potential abusers³².

It is difficult to draw firm conclusions and determine causality

Challenges with being a parent

Some survivors of CSA have happy and fulfilled relationships with their children that are similar to parents who were not abused as children³³. In fact some survivors talk about becoming a parent as a turning point in their recovery when they decided to seek help or support for the childhood abuse. Others may find the parenting role challenging, and this appears to be more likely when there were other adverse factors experienced during childhood in addition to the CSA³⁴. Although many parents also show these behaviours, survivors of CSA may be more likely to:

- over-monitor the child's behaviour
- find it hard to support age appropriate independence in the child (either too restrictive or too permissive)
- show role reversal with the child
- find it difficult to deal with child's sexuality and sexual development
- be over protective of their children
- not trust others in relation to their children (but in some cases this may be justified)
- experiencing problems caused by emotional disconnection
- experience a resurfacing of the CSA trauma following the birth of their own child
- symptoms of post-partum depression
- low parenting confidence (and be more likely to judge their parenting more harshly even if objective observers rate it their parenting as good).

Fathers who experienced CSA may also have:

- Difficulties with touching their own children
- Experience prejudice against them regarding their interactions with children
- Fear abusing own children.

Practitioners who are working with parents should be aware of the client's family environment. If an individual's energy

reserves are being used in recovery work for themselves, this may have a knock-on effect on the resources they have for being a parent.³⁵ Clients may need to be supported to consider what other people or supports they can draw on during their recovery journey to also help them with their responsibilities as a caregiver. This could include identifying someone who could look after the children for a while to give the parent a break.

Becoming a perpetrator of abuse

It is a common misperception that people who have been sexually abused as children will repeat the cycle and themselves become perpetrator of abuse³⁶. The studies which examine this issue vary widely in how the samples are drawn and how much confidence we can have in generalizing their findings to the general population. The vast majority of individuals who experienced CSA do not go on to abuse other children. One Australian study followed people for over 45 years who had been sexually abused as children³⁷. The authors concluded that 99% of the men and women who had been sexually abused as children were never convicted of a sexual crime. They did have a slightly elevated risk of being convicted of a sexual offence compared to the control group, but their actual risk of offending was low. Some studies suggest that prevalence of CSA is higher amongst sexual compared to non-sexual offenders, and also amongst offenders who abuse children in comparison to those who offend against adults. However, the relationship is relatively weak and is often only indirect rather than causal in nature³⁸.

People may also be concerned that there is a link between the type of childhood abuse experienced and the nature of any sexual offences committed in later life. In fact childhood physical abuse is a stronger predictor of committing sexual crimes later in life, rather than childhood sexual abuse³⁹.

Men have a greater risk than women of progressing from victim to abuser, however

It is a common misperception that people who have been sexually abused as children will repeat the cycle

the majority of male victims do not become perpetrators. Factors in relation to the abuse itself that have been found to increase the likelihood of becoming an abuser are⁴⁰:

- being victimised by a female member of the family, particularly the mother or sister
- being offended against by someone outside of the family
- when the abuse occurs in the pre-pubertal years, the perpetrator is female and the victim does not acknowledge the events as abusive.
- being older than 12 when the abuse started.

Qualitative research has explored men's reflections on how they perceived they have avoided becoming perpetrators themselves⁴¹. Common themes included:

- being able to reject certain traditional norms of masculinity such as stoicism, aggression, and sexual prowess and instead creating a different male identity for themselves, sometimes involving sport and physical fitness

- using risk management strategies such as being:
 - in tune with and open about their feelings and vulnerabilities,
 - having empathy for possible victims
 - using the learning about how their own experiences with abuse had effected them, and not wanting to inflict such suffering on others
 - using socially acceptable ways of dealing with anger
 - fostering good relationships with others and relearning intimacy skills
 - developing and communicating sexual boundaries.

Some of the men reflected how this process was difficult as they struggled to control deviant and violent fantasies and impulses. The research suggests that resiliency in this context is an ongoing process rather than an attribute. Some of the men said that they had made a conscious decision not to become a sexual offender, and they could clearly remember the precise moment when they made this decision. Sometimes the trigger to making



this decision was becoming aware of the topic of sexual abuse through formal or informal means of education.

Being able to identify what happened to them as abuse

Not everyone who has had childhood experiences that professionals would define as being CSA label these experiences as such, or see themselves as a victim of abuse⁴². Even though they can remember the events clearly, these individuals do not acknowledge their history of victimisation and they label the events as something other than CSA.

Men are less likely than women to acknowledge their victim status with respect to sexual victimisation⁴³. Between 15%-69% of men who objectively meet the criteria for being considered a victim of CSA actually acknowledge that their experience was abuse. However men are more likely to acknowledge CSA than adult rape⁴⁴.

Men's general reluctance to acknowledge victimisation may be partly due to boys experiencing CSA at a slightly older age on

average than girls, and their perpetrators being more likely to be female. Stander, Olson and Merrill (2002⁴⁵) propose that since boys and young men are socialised to view themselves as the instigators of sex or the seducers of women they fail to acknowledge the age and associated power differentials between themselves and their abusers. Consequently, they are more likely to perceive these sexual encounters as being consensual or arising as a consequence of miscommunication. In doing so, they are less likely to experience psychological distress since this appraisal of the events neutralises their victimisation experiences, and they are able to protect themselves from the conscious awareness of the betrayal⁴⁶. However, the negative effect of lack of acknowledgement means that the individual may maintain a relationship with the abuser which places him/her at risk for further victimisation. They might also develop a distorted view of sexual relations between adults and children and as a consequence may more easily transition between being a victim to becoming a perpetrator⁴⁷.

Men are less likely than women to acknowledge their victim status with respect to sexual victimisation



With regards to the impact of acknowledgement of victim status on men, Airtime et al.'s (2014)⁴⁸ study found that unacknowledged adult sexual assault, but not CSA, was associated with higher levels of psychological distress. Conversely, acknowledged CSA was associated with higher levels of distress and risk for revictimisation. Overall, there does not appear to be a protective effect of acknowledgement of victim status.

Possible indicators of past abuse

How can we tell that an adult was sexually abused as a child? There is no single indicator or cluster of symptoms and/or behaviours that provides evidence of past abuse. The most reliable indicator is if someone decides to tell you that they were sexually abused. There can be some clues, although it is important to remember that all of these can also be shown by people who did not experience CSA. There is, however, a growing body of evidence that documents a relationship between adverse childhood experiences and certain behaviours which could be observable as 'symptoms' in later life including⁴⁹:

- Avoidance of all health care practitioners and/or health serving agencies, or conversely an increased tendency to seek out health care services

- Repeated cancellations of appointments
- Repeated postponement of physical exams
- Poor adherence to medical recommendations
- Chronic unexplained pain (e.g. headache, pelvic, back, muscular)
- Unexplained gastrointestinal symptoms/ distress
- Disordered eating, obesity, or wide fluctuations in weight
- Sleep disturbances (insomnia, hypersomnia)
- Sexual problems (e.g. avoidance, many sexual partners, unsafe sex practices)
- Alcohol or drug misuse
- Depression
- Pattern of difficulty in interpersonal relationships
- Self-harm behaviours and/or suicide ideations/ attempts
- Post-traumatic Stress Disorder or other anxiety problems
- Dissociative states (blacking out, long silences).

These indicators may stem from other causes, but are often associated with childhood abuse.

Summary

The effects of Childhood sexual abuse (CSA) are not always obvious, either during childhood or in adulthood. There is variation between individuals, both in terms of when problems emerge as well as what those difficulties are. Survivors may experience difficulties in psychological wellbeing, social functioning and health. Some indicators may be present that individuals have experienced trauma in their past.



RESILIENCE & RECOVERY

Risk and protective factors, and the process of recovery

General risk factors for negative outcomes

Factors in childhood that have been found to increase the risk of having an adverse and/or a prolonged response to CSA include issues such as⁵⁰:

- intra-familial abuse where the victim and perpetrator are related
- abuse starting at a young age
- multiple perpetrators (either during the same incident or from successive abusive incidents)
- the severity of the abuse (both the degree of force used and the nature of the sexual acts)
- the duration of the abuse
- experiencing a negative response to a childhood disclosure. Survivors who disclose are often disbelieved or blamed by those whom they tell. There is some evidence to suggest that the response to disclosure may

be the most predictive factor of later negative outcomes.

Protective factors

Some adults who experience CSA show poor outcomes across a variety of areas⁵¹. Others do not experience these issues, or experience them to a lesser extent. It is suggested that up to 50% of survivors of CSA do not exhibit the most severe long-term psychiatric disorders, and between 15% and 47% show few or no symptoms in adulthood⁵².

Protective factors in the childhood environment include⁵³:

- educational engagement and/or attainment
- involvement in extracurricular activities
- having one supportive and stable caregiver
- having an emotional bond with someone which allows for the

- development of a sense of autonomy, trust and initiative
- having a positive adult role model and mentor (these might be friend's parents, teachers, neighbours, grandparents, older siblings etc.).

Educational engagement, attainment and contentment in school appear to be the most important factors associated with resilience in adult samples⁵⁴. It may be that all of these protective factors in the child's environment help to make children more resilient and thus less affected by the abuse. Alternatively they may help the child or young person find adaptive ways of coping in the aftermath of the abuse⁵⁵.

It is also possible that particular personality characteristics encourage resilience in children who have been sexually abused. Protective characteristics relating to the individual include⁵⁶:

- optimism
- an internal locus of control
- high self-efficacy
- high intelligence
- having a sense of hope for the future
- being socially skilled
- high self-esteem and sense of self-worth
- being able to find meaning and a sense of personal growth in response to the abuse
- attributing blame to the perpetrator rather than themselves.

Recovery

Recovery relates to each person's ability to live a fulfilling life. It is unique for each individual. It is more than the elimination of symptoms of mental ill-health. Survivors of CSA describe recovery as including:

- Acceptance over what has happened
- Making peace with one's self
- Connecting with others and feeling competent and accepted in interpersonal relationships

- Regrouping and being able to trust others
- Talking about one's experiences
- Making links to substance misuse recovery
- No longer feeling hatred and fear
- Feeling safe
- Feeling comfortable with emotional and sexual intimacy
- Gaining self-confidence
- Able to be assertive
- Ability to embrace vulnerability
- Living a satisfying life
- Stopping the cycle of abuse
- Attaining spiritual transformation
- Engaging in altruism.

Survivors often identify turning points when their recovery took either a positive or negative turn. They may experience several turning points on their road to recovery. Positive turning points can provide a profound sense of well-being, a change in understanding and the realisation that there is hope for a better future⁵⁷. They are often underpinned by a sense of hope, when survivors see their lives and what has happened to them in a different way, and experience a greater sense of control over who they are⁵⁸. Common positive turning points for male and female survivors of CSA include⁵⁹:

- Fear of losing their children
- Wanting better lives for their children
- The need to remember so as to not repeat the past
- Realisations and changes that happen gradually – e.g. tiring of old maladaptive behaviour patterns
- Social support
- Environmental opportunities
- Spirituality
- Realising that the abuse wasn't their fault
- Not wanting the abuse to continue to affect their lives

Educational engagement, attainment and contentment in school appear to be the most important factors associated with resilience

- Seeking therapy
- Confronting the abuser
- Volunteering and helping others
- Disclosing to a friend
- Coming to a new understanding.

Models of trauma recovery

Several models have been developed to describe the process of recovery following trauma. Some general models relate to a range of different traumas; others are specific to CSA. Herman's Stage Based model is detailed below to show the different types of coping strategies which

Table 2 – Coping strategies used at different recovery stages (according to Herman)⁶¹

Type of Coping	Healing stage	Coping strategy	Gender likely to use this strategy	Examples
Avoidant Coping	Establishing Safety	Dissociation	Female Male	Feeling disconnected from one's body Feeling as though one or the situation isn't real
		Deliberately suppressing memories	Female Male	Intentionally trying not to think about the abuse
		Denial	Female Male	Believing that the events didn't happen or not seeing them as abusive
		Escapism	Female Male	Day dreaming Wishful thinking Being pre-occupied Keeping busy Substance misuse
		Avoidance of the abuser	Female	Breaking away from the family Ensuring perpetrator is not around during visits
		Avoidance of 'risky' situations	Female	Restricting activities, not dating etc.
		Emotional Apathy	Female	Not feeling happiness or sadness – a sense of lateness of feeling
Active Coping	Processing the traumatic experiences	Seeking social support	Female Male	Disclosing to friends, family or professionals Joining a peer support group either on-line or in person Seeking and engaging with therapy
		Spirituality and spiritual support	Female Male	Seeking support from religious leaders Finding encouragement and protection in religious beliefs and practices Engaging in spiritual pursuits (e.g. meditation, nature etc.)

Type of Coping	Healing stage	Coping strategy	Gender likely to use this strategy	Examples
Active Coping continued	Processing the traumatic experiences continued	Cognitive reappraisal	Female Male	Attributing blame to the perpetrator Downward comparison Minimisation and normalisation Self-reflection and sense making
		Emotional Expression	Female	Give one's self permission to cry and to feel the pain
		Coping on one's own	Female	Taking time to go within and to reflect on life. Making an attempt to break from dependency on (potentially harmful) others
		Talking about the abuse	Female Male	Finding voice and sharing experiences with others
		Working through the abuse experience	Female Male	Making sense of what happened, forming a coherent personal story, finding meaning from one's experience
	Reconnecting with others and forming a new life path	Education (Formal and reading self-help literature)	Female Male	Studying to increase self-confidence To aid meaning-making Self-help literature fosters hope
		Confronting the abuser	Female Male	Face-to-Face Writing a letter Imagined confrontation
		Positive thinking	Female Male	Strengthened personality Assertiveness Confidence Empowered Less naïve In control More empathic of others
		Survivor Advocacy	Female Male	Joining campaigns for political change in relation to social injustices Writing about survivor issues with a view to gaining support for other survivors
		Altruism	Female Male	Volunteering Helping others Demonstrating compassion for others

Different types of coping strategies will typically be employed at different stages of recovery

may be used at different stages of recovery. Herman identified three stages of recovery (Table 2)⁶⁰:

1. Establishing safety, which included symptom mastery and establishing routines of self-care. This can only be established through the development of a satisfactory treatment alliance.
2. Exploration and processing of the traumatic experiences
3. Reconnecting with others – establishing mutual and non-exploitative relationships.

Overall, recovery from CSA appears to be an active process on the part of the individual and arises as a consequence of their own attempts at coping. Different types of coping strategies will typically be employed at different stages of recovery. Avoidant coping (which is often seen as the opposite of active coping) is more likely to be used in the crisis stage of a trauma. In the context of CSA this might be at the point of the first disclosure, on first recalling memories of abuse or when the individual first acknowledges that their experiences were abusive in nature. Whereas, active coping would be used during the meaning-making and the creating a new-life path stages of recovery.

Qualitative research provides some insight into the different factors which may influence rate of recovery:

- Starting recovery – Factors that may delay someone starting on their recovery journey may include⁶²:
 - Family's denial of abuse that enforces a sense of secrecy
 - Ambivalence about moving on with life – a sense of safety gained from maintaining the status quo and fear of losing control
 - Perpetrator is still in their close environment
 - Using avoidance strategies to 'run from the abuse' (e.g. becoming a workaholic)

- Slowing the rate of recovery – factors thought to slow down progress may include:
 - Wanting quick fixes to their problems in living in the aftermath of CSA
 - Unhelpful responses to their disclosures
 - The desire to protect others from the stigma and distress which drains their energy reserves
- Supporting the rate of recovery – Factors found to enhance recovery included:
 - Disclosing and shifting blame onto the perpetrator
 - Building inner strength and resources (e.g. assertiveness, self-respect, self-compassion etc.)
 - Formalising a complaint against the perpetrator – felt to be both validating and empowering by some survivors.

The difference between resilience and recovery

The distinction between recovery and resilience is an important one to consider when working with and alongside survivors⁶³. When an individual 'recovers' from a trauma they are likely to display a different trajectory of psychological functioning to that of someone who is resilient in the face of adversity.

Recovery: The recovery trajectory is characterised by a significant decline in well-being in the immediate aftermath of the traumatic events and a rise in symptoms of pathology which may last from several months to a number of years. Subsequently, there is a gradual improvement in functioning and a reduction in pathology until the individual achieves a level of functioning and well-being which is equivalent to that which they evidenced prior to the trauma (Figure 4).

Resilience: In contrast, resilient individuals are able to sustain relatively normal levels of

Figure 4 – An example of a recovery trajectory

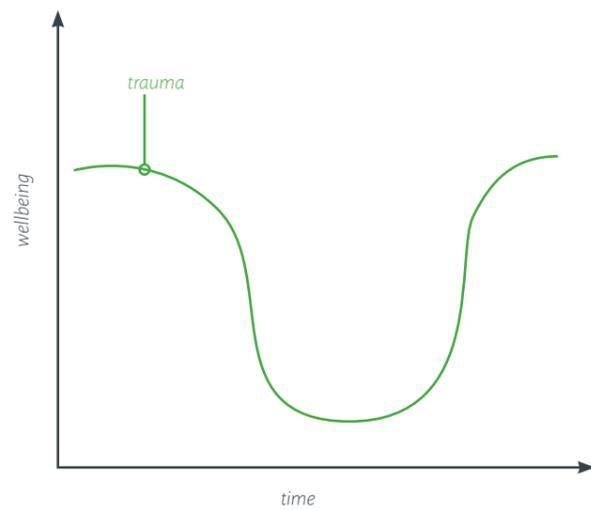
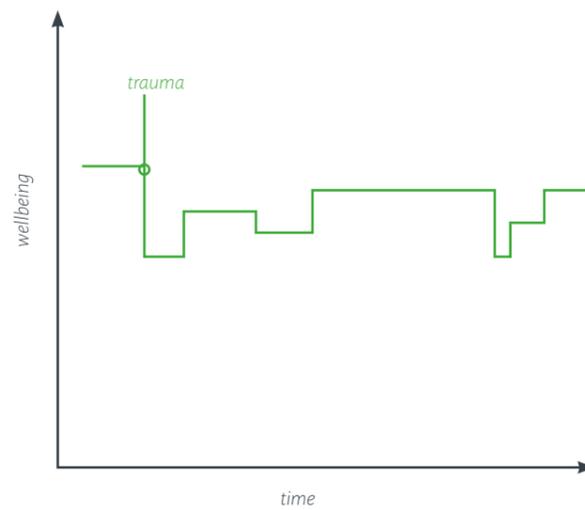


Figure 5 – An example of a resilience trajectory



healthy functioning after exposure to a potentially traumatic event. They show a more stable trajectory through the event and its aftermath. In the first few weeks after a stressor or trauma, they may experience disruptions to functioning such as problems with sleeping or intrusive thoughts. Importantly, resilient individuals are still able to experience positive emotions and more likely to engage in caring behaviours even in the extreme circumstances (Figure 4).

It can be tricky to draw out practical implications from the thinking around resilience for practice settings. There are a number of difficulties in operationalising the concept of resilience and people disagree over whether it is a personality trait or a dynamic process, and also whether it should be measured in just one area of a person's life or across several different domains⁶⁴.

Post-traumatic growth

Some individuals who have experienced trauma (whether as children or adults) can return to a similar level of functioning and wellbeing as they experienced before the trauma. Others may show a better level of functioning after the trauma than

before and this is known as post-traumatic growth (PTG)⁶⁵. It is estimated that 50% of survivors of trauma view their traumatic event as having been a catalyst for personal adaptation and positive change relating to how they see themselves, their relationships with others and/or general life philosophy. Key aspects of post-traumatic growth are an increase in compassion for others and engagement in altruistic behaviours.

Some adult survivors of CSA show post-traumatic growth⁶⁶. This appears to depend less on the nature of events than on how events are appraised by the individual. Post-traumatic growth may be more likely to occur when⁶⁷:

- there is a perceived threat to life
- there is an existential struggle surrounding the events ('why me?' type questioning)
- the individual is able to create meaning out of events that appear meaningless
- the individual feels in control of their recovery process
- social support can help the survivor feel in control over their recovery process which in turn impacts on the perception of positive life changes.
- having the opportunity to talk about

the abuse. This may let the individual cognitively process the trauma and formulate new meanings and ways of coping.

CSA, ethnicity, resilience and coping

There is emerging evidence on the importance of taking cultural differences into account when working with adult survivors. Although these are small-scale qualitative studies, they provide useful insight into how important cultural perspectives can be for individuals (rather than highlighting approaches that will work for all members of these communities). They highlight the importance of tailoring support to an individual's needs and preferences, and the need for the practitioner to understand how the abuse fits with their 'world-view' or cultural perspective.

Qualitative research with South Asian immigrant women in America identified four inter-related issues in relation to culture⁶⁸:

- Strict gender socialisation – Women and girls have a subordinate role to men, but are deemed to be responsible for their abuse and thus it is them who are shameful.
- Maintenance of family image – In South Asian culture the family takes priority over the individual and thus the survivor of CSA is burdened with protecting the family image. The loss of virginity, which is culturally highly valued in girls, is seen to damage the family reputation and prospects.
- Influence of ethnic identity – Ethnic identity served as both a hindrance and an enhancer of their resilience. The effort that was taken from them managing racist harassment and abuse was time stolen from their efforts at healing from CSA. However, having a strong ethnic identity permitted them to develop assertiveness and a sense of pride through their connection with the South Asian community, which provided them with culturally defined ways of healing.



- Acculturative stressors – Acculturation was often felt to be creating a divide between parents and the younger generation, as typically the young people were more immersed in the US culture and associated values and belief systems. Thus parents were seen as less able to provide support in relation to some aspects of the young people's lives as it was outside of their own experience.

The coping strategies used by these South Asian women included:

- Maintaining a sense of hope
- Use of silence – used to separate from others to give themselves space to heal. Whilst the women were not happy about the fact that silence about the abuse was imposed on them, they did report using this as a positive coping strategy. They felt it was important for them to have a choice in when, where and with whom to break the silence.
- South Asian social support – Safe South Asian social support before, during and after the abuse was felt to assist in their healing and resiliency. This fulfilled the need for belonging.
- Social advocacy – They gained a sense of purpose through academic, career, volunteering and advocacy pathways.
- Intentional self-care – taking care of one's mind and body was used as a means of compensating for the harm done to them through the abuse.

Research with 10 adult survivors of CSA who were of African origin provides different insights into the experiences of this group and their preferred coping strategies⁶⁹. These women of African origin:

- Expressed a desire to attend counselling with their family member who abused them
- Found healing through collective and community processes rather than individual methods. They preferred group work/ peer support, specifically where this was with other women from the same ethnic group.

- In this study, four out of 10 of the women confronted their perpetrators
- They reported fearing adding fuel to racist and sexist stereotypes against their ethnic group and community as a result of their speaking out about their abuse.
- Their potential for healing can be circumscribed by the myth of the 'strong Black woman'
- Had to integrate multiple identities as a survivor. All the messages they receive through the media, families, work, religion etc. refer to the disempowered and marginalised nature of their ethnic, gender and survivor identities. Often they felt the need to split identities as a result of societal oppression and thus some felt they were betraying their 'Black woman' identity when stepping out as a survivor. Thus, formation of a salient identity (e.g. in relation to sexual orientation or class) influences their journey to recovery.
- Religion and spirituality are often very strong sources of healing, but can also be sources of further oppression and abuse.

Therapists should be skilled in exploring how racism, sexism, and classism is affecting the client's life and their path to recovery. They need to understand what the abuse means in terms of the client's world perspective and culture, so that they can provide tailored support which meets their needs in an appropriate way. Developing a response will involve understanding the needs of the individual within their own cultural context. For example, a strong South Asian identity can help South Asian survivors of CSA to access culturally accepted ways of healing (e.g., yoga, meditation) from the abuse, which simultaneously protects them from some of the negative effects of racism. Two assessment tools have been recommended by Singh et al⁷⁰. when working with ethnic minority survivors: a) Culturally Sensitive Assessment Tool⁷¹ or b) Cultural Values Conflict Scale for South Asian Women⁷².

Therapists need to understand what the abuse means in terms of the client's world perspective and culture

Summary

Not all individuals show the same outcomes and this is partly due to individual characteristics, as well as factors in their surrounding environment.

Recovery can be a long process that happens gradually. Although common stages can be identified, recovery is a unique process for each individual.

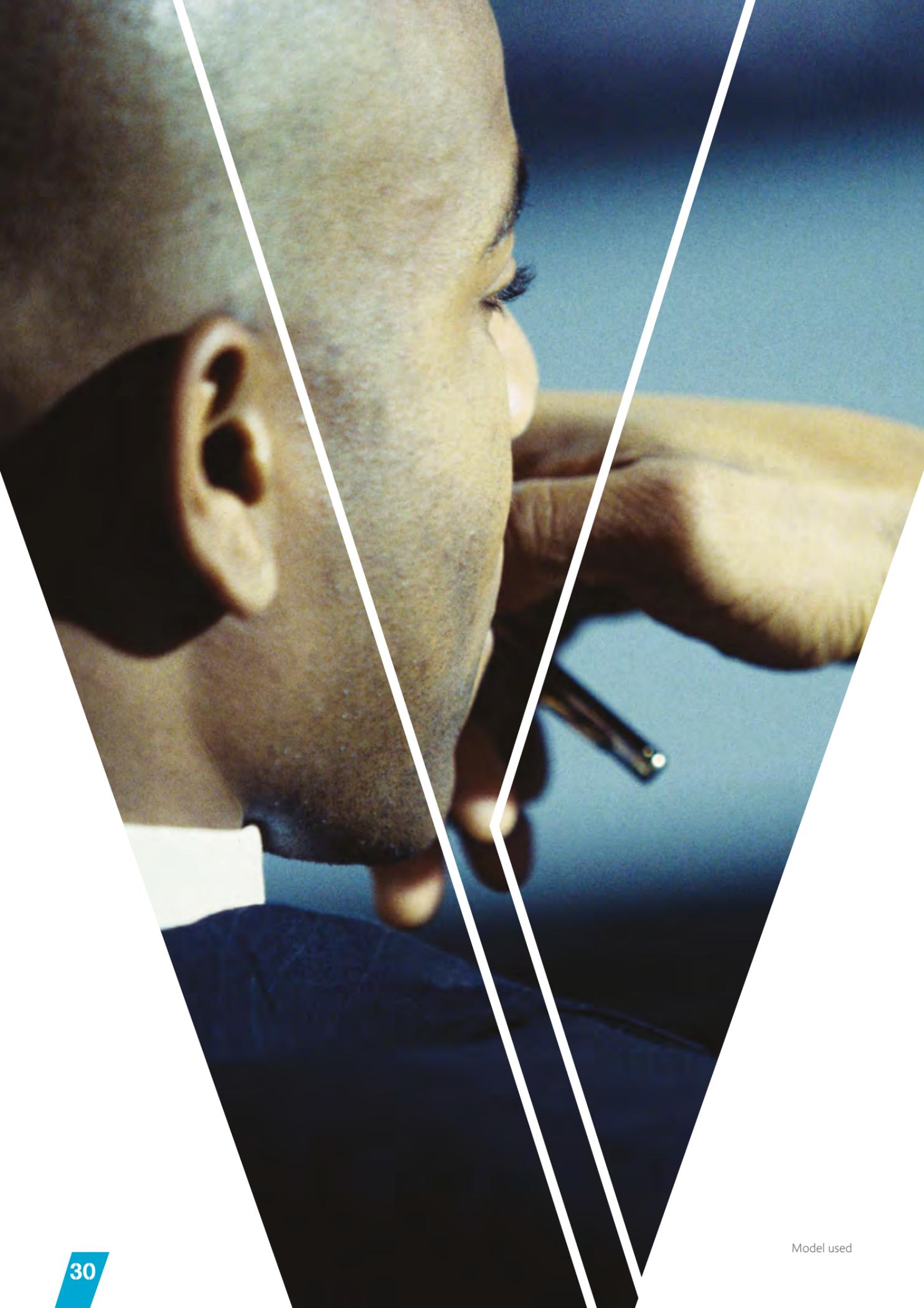
Recovery isn't necessary a smooth linear process. Sometimes there can be negative turning points (e.g. new life stressors) which can lead to a temporary loss of adaptive functioning. Positive turning points can significantly accelerate the rate of progress.

The key processes of recovering are eliminating or learning to manage the unpleasant thoughts and emotions, making sense out of what has happened and moving forward with a new enthusiasm for life.

We need to understand what the abuse means in terms of the client's world perspective and culture, so that we can provide tailored support which meets their needs in an appropriate way.

There is a difference between how resilient individuals cope after trauma and how other individuals who use adaptive coping strategies improve over time. Some individuals will be able to return to similar levels of wellbeing as those experienced before the trauma. Some people may even show post-traumatic growth and show better functioning than before the trauma.

Recovery can be aided by a number of different resources and activities including, therapy, social support from others, education, volunteering, spirituality and confronting or making a formal complaint against the abuser.



WORKING WITH SURVIVORS

Developing sensitive practice

The Public Health Agency of Canada⁷³ commissioned a practice guide in 2008 to guide sensitive practice for health practitioners for working with adult survivors of childhood sexual abuse. The authors highlighted some of the characteristics of adult survivors which may make engagement more challenging. These may include:

- Mistrust of authority figures which may stem from having been betrayed by trusted adults during childhood. Practitioners need to take active and ongoing steps to demonstrate their trustworthiness.
- Difficulty in stating what their needs are, because during the abuse they do not get to choose what happens to them. Abuse can teach children to avoid speaking up or questioning authority figures.
- An ambivalence towards their body and reticence to seek care for health problems. Some may show self-harm

in the form of scratching, cutting or burning the skin. Self-harm can also be more subtle, such as ignoring health advice, or recommendations for treatment or symptom management.

- Fear and anxiety, particularly about what will happen to them during an encounter with the professional.
- Never having told anyone or many other people about the abuse previously. This may be for several reasons including a fear of not being believed, feeling responsible for what happened, fear that others will blame them, previous negative experiences of disclosure.
- Male victims of childhood sexual abuse may also feel particularly invisible as survivors because of the lack of knowledge about the prevalence of childhood sexual abuse of boys, society's notions of masculinity and victimhood, and services for childhood sexual abuse survivors may be historically designed for women rather than for men. Male survivors talk

about needing to appear ‘tough’ and ‘in control’ and often having difficulty in identifying and expressing their feelings.

- Survivors may have questions about their sexuality and sexual orientation.
- The emotional cost of victimization for male survivors is also exacerbated by the erroneous societal belief that it is only a matter of time before they become abusers themselves, if they have not already done so. Female survivors may also fear that they are destined to become perpetrators or that others will see them as potential offenders.
- Transference is said to occur when an individual displaces thoughts, feelings and/or beliefs about past situations onto a present experience. We all do this, to some extent, but sometimes it can interfere with healthy and adaptive functioning. The dynamics of transference help explain why a survivor may respond to an interaction with a practitioner in a way that is unrelated to the encounter or to the specific practitioner. Understanding transference helps practitioners to avoid taking patients’ negative responses personally. Counter-transference relates to how the practitioner then responds with thoughts, feelings and/or beliefs associated with his or her own past. Practitioners must respond professionally, even in the face of

negative transference or hostility. It is more productive to ask the reasons for the patient’s hostility than for the practitioner to respond with anger. Practitioners should be supported to reflect critically on their practice, and avail of the support available from their supervisor and other members in the team.

- Survivors may also dissociate during certain interactions. Dissociation is a ‘disruption in the usual integrated functions of consciousness, memory, identity or perception of the environment’ that may be sudden or gradual, transient or chronic. Many believe that dissociation is an effective strategy for coping in the immediate situation with extreme stress such as childhood sexual abuse. However, if it becomes a long-term coping mechanism it may contribute to a variety of mental health problems and interfere with relationships, self-concept, identity development and adaptive functioning.

The ASCA (Adults Surviving Child Abuse) is an Australian organization which works with survivors of abuse. They reviewed clinical guidelines and empirical research and produced the following set of delivery principles for working with adult survivors. These have been accepted as a clinical resource by the Royal Australian College of General Practitioners⁷⁴ (Table 3).

Survivors may dissociate during certain interactions

- | | |
|--|--|
| 1. Provide a safe place for the client | 7. Have a broad knowledge of trauma theory and provide the client with psycho-education |
| 2. Ensure client empowerment and collaboration | 8. Teach clients adaptive coping strategies (i.e. teach clients self-care, distress tolerance strategies and arousal reduction strategies) |
| 3. Communicate and sustain hope and respect | 9. Teach clients to monitor their thoughts and responses |
| 4. Facilitate disclosure without overwhelming the client | 10. Teach clients interpersonal and assertiveness skills. |
| 5. Be familiar with a number of different therapeutic tools and models | |
| 6. View symptoms as adaptations | |

Table 3 – Delivery principles for working with adult survivors

Each of these delivery principles is described below:

1. Provide a safe place for the client

- childhood trauma and abuse are, at their core, about feeling unsafe, and it can be challenging for clients to build a trusting relationship. It takes time. Practitioners must be patient. Periodically checking with the client about how they are experiencing the therapeutic relationship may help the client identify issues of mistrust.

2. Ensure client empowerment and collaboration

- survivors benefit most when they participate actively in treatment and have control over decisions that affect them. Supporting clients to maintain a sense of control over which therapeutic issues are addressed can help clients manage overwhelming feelings better. Clients appreciate being given choices and also when practitioners acknowledge the clients’ insights and ideas about their own recovery. Encourage clients to value their own needs because often they will have been taught as children to attend exclusively to others while dismissing their own needs.

3. Communicate and sustain hope and respect

- Respect can be shown in how the practitioner talks to the client, respect for confidentiality, punctuality, sensitive use of language, the practitioner admitting when they make a mistake or feel unsure and valuing the client as having a valid point of view. Hope should be shown by the practitioner’s words, action and body language. Help the client to identify the resources they already have (e.g. sense of humour and defence mechanisms, interpersonal resources such as friends, family, pets, belief system etc.).

4. Facilitate disclosure without overwhelming the client

- there is disagreement in the literature over how important disclosure is in the therapeutic process. It is clear though, that survivors should never feel ‘forced’ to disclose their

past experiences. For some, disclosure can be overwhelming and can trigger automatic childhood responses such as running away, avoidance or denial. Some professionals feel there is little to be gained from this. Other professionals believe that disclosure helps to externalize those past experiences and can help the survivor separate themselves from the abuse experiences. Barriers to disclosure may include coping strategies (such as denying, minimizing, or dissociating, and the desire to please other people), self-blame, shame and guilt, the ability to hide one’s true feelings, fear of punishment from the perpetrator, fear of the therapist’s response, confusion, difficulties putting the trauma into words and fear of being ridiculed or not believed. If a client feels ready to disclose, the practitioner should use active listening skills. Therapists who listen to the survivor, ask clarifying questions, name the client’s experiences and do not overly challenge what the survivor says, help the survivor make the most progress. Often simply repeating what the survivor has said out loud helps to validate his/ her thoughts and feelings in ways that have never been validated before. This can be one of the best approaches to take even if the client is not ready to deal with other issues at that time. Harmful responses include ignoring the disclosure, rushing the client, being silent, not believing the client, or not providing any further supportive action after the disclosure.

5. Be familiar with a number of different therapeutic tools and models

- it is important to adapt the therapy to the client, rather than expecting the client to adapt to the therapy. This is easiest when practitioners are trained in several different treatment approaches to allow tailoring to the needs and preferences of the client.

6. View symptoms as adaptations - it is important to understand that coping strategies that the client used as a child helped them try to cope with the abuse

Survivors benefit most when they participate actively in treatment and have control over decisions that affect them

but may not be helpful in present life situations. Reframing feelings and behaviour in this way can be the beginning of positive change. Clients can find it helpful when practitioners held them to understand their feelings and coping strategies in the context of their specific abuse history.

7. Have a broad knowledge of trauma theory and provide the client with psycho-education – practitioners should provide accurate information about the nature of trauma and its effects to clients and work with them to integrate this new information and its implications into their overall perspective. If providing self-help material, it is important to encourage the clients to notice their reactions, thought and feelings in response to the materials, and to stop reading if they feel distressed or overstimulated.

8. Teach clients adaptive coping strategies (i.e. teach clients self-care, distress tolerance strategies and arousal reduction strategies) – although childhood coping strategies may have been functional at the time of the abuse many are not helpful in present day situations. It is important to help survivors develop more adaptive coping strategies rather than risk making matters worse by getting rid of maladaptive defences and leaving the client with no coping strategies. Adaptive coping strategies can include teaching them self-care strategies, distress tolerance strategies and arousal reduction strategies. These can help reduce stress and promote healthy neuro-endocrine function. Clients may never have learnt to 'self-soothe' or 'self-care'. It can be hard to learn these skills as they have to develop a new understanding of themselves as human beings with the right to feel comfortable, safe and worthwhile. Distress tolerance strategies can include distraction, self-soothing, improving the moment and thinking of pros and cons. Arousal reducing strategies can include distracting your thoughts (particularly in states of hyper-arousal such as anger or anxiety) and breathing control exercises.

9. Teach clients to monitor their thoughts and responses – a very effective approach to use with trauma survivors is Cognitive Behavioural Therapy (CBT) which works with cognitions to change emotions, thoughts and behaviours. Clients learn how to cope with anxiety and negative thoughts, manage anger, prepare for stress reactions, handle future trauma symptoms, learn healthy coping strategies (rather than 'self-soothing' with alcohol or drugs) and how to communicate effectively with people.

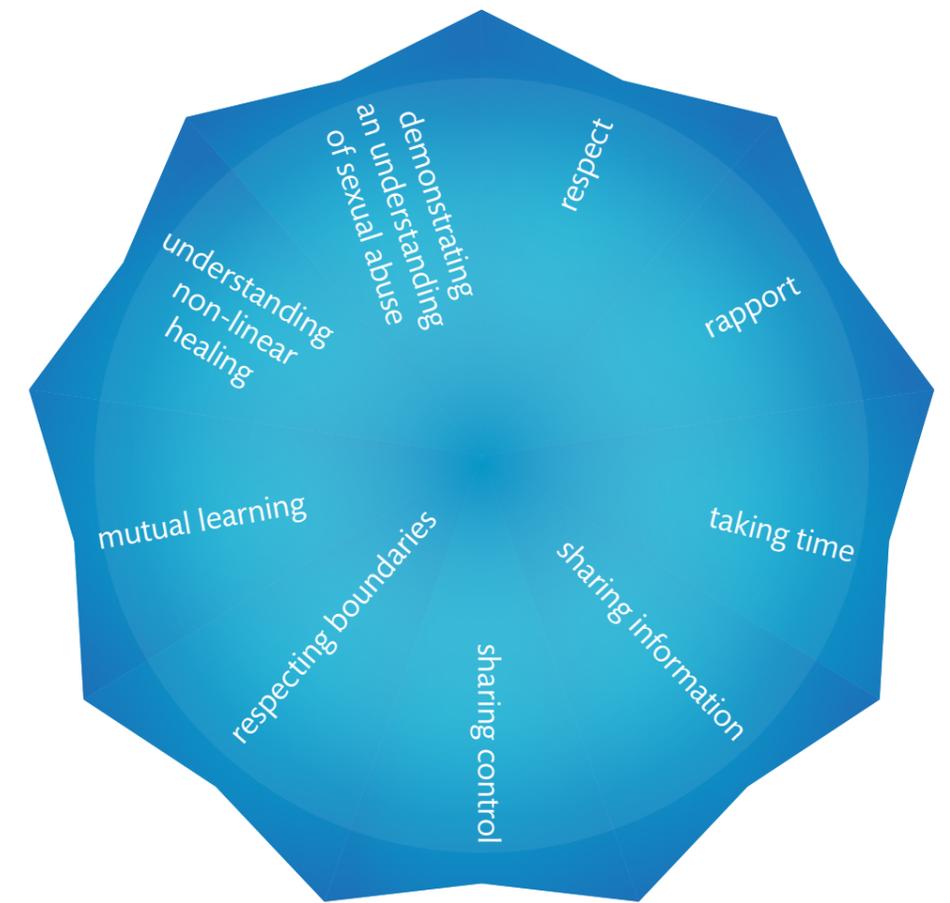
10. Teach clients interpersonal and assertiveness skills – adults who were abused as children often experience difficulties in interpersonal relationships. Helpful strategies can be increasing the clients' assertiveness such as developing effective strategies for asking for what one needs, saying no and coping with interpersonal conflict.

The overarching consideration when working with adult survivors of childhood sexual abuse is to foster feelings of safety for the survivor. Schachter et al. (2008, p.18) identified 9 principles of sensitive practice and recommended that they should become routine practice or universal procedures, similar to those used for infection control guidelines: "Just as a clinician in a health care setting may not know an individual's history of past infection, they may not know an individual's abuse history. By adopting the principles of sensitive practice as the standard of care, health care practitioners make it less likely that they will inadvertently harm their patients or clients." The 9 principles of sensitive practice are shown visually in an umbrella (Figure 5) and described below.

1. Respect – because abuse undermines an individual's personal boundaries and autonomy, survivors may be sensitive to any hint of disrespect. They need to feel accepted and heard by the practitioner and know that they will not be judged even if they show how they are really feeling. The practitioner should avoid glib or false assurances which sound dismissive

The overarching consideration is to foster feelings of safety for the survivor.

Figure 6 – Umbrella of Safety



or indicate lack of understanding of their concerns. For example, instead of saying 'Don't worry, you'll be fine', say 'I know this is difficult. How can I help you to feel more comfortable?'

2. Rapport – practitioners who are warm and compassionate facilitate good rapport and subsequent feelings of safety. Clients should feel that the practitioner is interested in them. Practitioners should be fully present and patient-centred. They should develop a tone that is professional and still caring without being overly familiar. This will help promote a sense of safety and maintain appropriate boundaries.

3. Taking time – survivors may feel de-personalised or devalued and being rushed because of time pressures may diminish their sense of safety. Time pressure may

force a practitioner to become too task-oriented rather than really listening to their clients. Instead they need to stop and really listen to the client since feeling genuinely heard and therefore valued can be healing in itself.

4. Sharing information – it is important that survivors know what to expect as this decreases anxiety and prevents them being triggered by unexpected events. Taking a few minutes at the start of the appointment to explain what is going to happen can be helpful, or even providing some written information beforehand about what is involved in the appointment.

5. Sharing control – a central aspect of sexual victimization is the loss of control over one's body. Therefore, having a sense of personal control is crucial to establishing

and maintaining safety. Contracts for care, practitioner service contracts and other therapeutic contracts (either written or verbal) can all be tools for articulating goals, clarifying roles and responsibilities, and defining the parameters of the helping relationship. A frank, matter-of-fact discussion of these issues should be part of the treatment plan as it helps to minimize miscommunication and misunderstanding and increases trust. Individuals should be supported to be active participants in their own care rather than passive recipients.

6. Respecting boundaries – this is particularly important for survivors when asking for information of an intimate nature without explanation or permission, or if the practitioner is required to work in close physical proximity to the client. For example, asking a very personal question before establishing rapport can be perceived as a psychological breach of someone's personal boundaries. By demonstrating respect for and sensitivity to personal boundaries, practitioners can

model healthy boundaries and reinforce the client's worth and right to personal autonomy. A client may also over-step the practitioner's boundaries by asking for longer appointments or sexualising their relationship with the practitioner. The practitioner should talk calmly with the patient about the situation and need for boundaries, without apportioning blame. They should also talk to a respected peer or supervisor about the situation.

7. Fostering mutual learning – many adult survivors are only learning about their sense of interpersonal safety in adulthood as they did not experience it growing up. They may need encouragement. Practitioners should be willing to learn from their experiences of working with survivors about how to develop sensitive environments and improve their practice.

8. Understanding non-linear healing – healing and recovery from childhood sexual abuse is not a linear process. There may be variations from day to day

A client may over-step the practitioner's boundaries



Model used

or over longer periods of time. Practitioners should check in with their clients throughout each encounter and adjust their behaviour accordingly.

9. Demonstrating awareness and knowledge of interpersonal violence – many survivors look for indicators of a practitioner's awareness of issues of interpersonal violence. This can take many forms such as posters and pamphlets on display from local organisations who work with survivors. This can help a client to know that they can raise an issue and the practitioner will be receptive and understanding. Materials should include a diverse range of images including men and women, and be ethnically diverse. The materials should be written in clear, plain language. As well as providing information about the organization and service, materials can also cue survivors to think about what they can do to facilitate their own safety and sense of wellbeing (e.g. bringing a support person to appointments).

Consciously applying these principles of sensitive practice can improve the therapeutic relationship with the survivor but also assist the practitioner to avoid re-traumatizing the patient. Schachter et al. (2008⁷⁵) produced a Handbook which describes practical ways on how to use these principles. It is over 100 pages long. Some of their suggestions are summarised below.

It is recommended that all staff including administrative staff and assistants are trained in applying the principles of sensitive practice in ways that work in their specific environments. Interactions with administrative staff and assistants can often set the tone for the practitioner-client relationship. Staff and assistants should establish a few "routine responses" that are survivor-friendly.

Waiting areas may also cause anxiety for survivors who as a result of the childhood abuse may be hyper-vigilant and watchful.

This can be helped by creating waiting areas that are warm and welcoming, providing and clearly identifying washrooms (separate for men and women), providing printed materials related to interpersonal violence, providing a realistic estimate of the length of wait time and offering the client a choice of where they sit in the room. Privacy is also important when confidential information is being discussed and it is important that this information cannot be overheard by others.

Prominently displaying posters and brochures for services that help survivors of interpersonal violence sends clients the message that the practitioner is aware of problems associated with sexual, physical and emotional abuse. Materials should provide information on:

- Sexual assault centres, women's centres, community mental health agencies and residential addiction treatment facilities
- Telephone help lines and suicide hotlines
- Accommodation for victims of domestic abuse
- Mobile crisis units.

The first few moments of an encounter between the client and the practitioner set the tone – the practitioner should introduce themselves, explain the nature of the appointment and ask the client how they wish to be addressed. It can also be useful to discuss the client's expectations so any apprehension can be quickly gauged and a relationship established which involves two-way sharing of information and control.

Encourage the client to ask questions throughout the visit or ask patients to make a list of questions for each future appointment in order to reduce their sense of anxiety.

Practitioners should also be attuned to the following behaviours in the client which may be non-verbal indicators of discomfort, distress or dissociation. These can be seen as signs of a 'flight or flight' response:

Applying sensitive practice can assist the practitioner to avoid re-traumatizing the patient

- Rapid heart rate and breathing (breath holding or sudden change in breathing pattern may also be seen)
- Sudden flooding of strong emotions (e.g. anger, sadness, fear etc.)
- Unhealthy paleness or flushing
- Sweating
- Muscle stiffness, muscle tension and inability to relax
- Cringing, flinching or pulling away
- Trembling or shaking
- Startle response.
- The following symptoms may be clearer indications of dissociation:
 - Staring vacantly into the distance
 - Spacing out or being uninvolved in the present
 - Being unable to focus, concentrate or respond to instructions
 - Being unable to speak.

After being triggered into a dissociative state the client may seem confused or vague. They may not be aware that they have dissociated.

Practitioners need to ensure clients do not leave the session feeling disoriented or embarrassed. Practitioners should use the following strategies to support them:

- Follow the SAVE protocol (this is described below on page 39)
- Bring clients gently back to the present by reminding them where they are and what was happening when they began to have trouble staying present
- Encourage slow, rhythmic “4-6 breathing” (inhale to the count of four and exhale to the count of six)
- Remind individuals to keep their eyes open and look around the room
- Encourage patients to notice physical sensations (e.g. the feeling of their back on the chair and their feet touching the floor, or the sensation of the air on their face).

As they become more oriented and responsive:

- Do not touch them.
- Offer verbal reassurance in a calm voice.
- Avoid asking complicated questions or giving complicated instructions.
- Offer them a glass of water.
- Allow them the necessary time and space to regain their equilibrium.
- Normalize the experience. Frame the normalizing comments in terms of anxiety that many people feel when seeing practitioners in these circumstances.
- Ask what the clients need right now (e.g. do they want your company or would be rather be left alone).
- Offer continuity of care (i.e. if time constraints prevent you from staying with upset clients as long as you would like, explain this and ask if someone else can help, such as another staff member or a friend whom you could call).

Being triggered can be a frightening and confusing experience. Practitioners should ask whether the client has someone to offer support and whether they would like to contact that person now. They should also find out whether clients would like to explore what has happened, whether they want a referral to a counsellor or other community resource, and whether they know about telephone help lines that exist in the community. The client may have difficulty in remembering information that the practitioner has provided, so it may be helpful to repeat this or write it down.

The next time the practitioner sees the client who has been triggered or dissociated it can be helpful to:

- Discuss the experience with the client to ensure they are feeling better and to reaffirm the message that the event does not alter the esteem in which they are held.

Practitioners need to ensure clients do not leave the session feeling disoriented or embarrassed

Some survivors may cancel appointments as a means of avoidance

- Problem-solve with clients to identify what to avoid or change in the future to prevent further triggering, keeping in mind they may or may not be able to identify the specific trigger.
- If required, suggest a consultation with a mental health practitioner to develop additional strategies for coping with triggers.

Most practitioners work under time pressure. Helpful strategies can include telling clients at the outset of the appointment how much time you have to spend with them and negotiating how best to use it. For example, “We have 30 minutes for this appointment, what do we need to focus on?” or “We have 30 minutes and I would like us to cover ..., is there anything else that you want to cover?”. The practitioner should also aim to keep interruptions from colleagues, telephone calls etc. to a minimum. The practitioner should also use both verbal and non-verbal communication to show their interest and attention.

It is important to also support transitions. For example, the transfer of care from one practitioner to another without prior notice

can evoke feelings of abandonment and erode trust. Announcing planned absences well in advance can be useful in allowing clients to prepare for them. In the best possible scenario practitioners are able to introduce their clients to the practitioner who is taking over.

Some survivors may cancel appointments as a means of avoidance. To help minimize cancellations practitioners might offer some ‘same-day’ appointments that would allow survivors to book appointments on days when they feel able to cope and also work with clients who have identified their apprehension and tendency to cancel appointments to develop a strategy that will assist them.

There may sometimes be emotionally charged or difficult situations with clients and the ‘SAVE the Situation’ acronym can help. SAVE has four steps (shown in Table 4, taken from Schachter et al. 2008, page 51): Stop, Appreciate, Validate, and Explore.

Practitioners also need to take care of themselves. They need to develop and use a repertoire of strategies that promote and maintain their own health, particularly during stressful or emotionally intense

The acronym **SAVE** is a guide for responding effectively and compassionately in a variety of emotionally charged situations

STOP	Stop what you are doing and focus your full attention to the present situation
APPRECIATE	Try to appreciate and understand the person’s situation by using the helping skills of empathy and immediacy. Empathy involves imagining the other person’s experience (thoughts, feelings, body sensations) and communication an understanding of that experience. Immediacy is verbalising one’s observations and responses in the moment, using present tense language. For example, “Your fists are clenches and you look angry. What is happening to you?” or “You seem upset” or “I doubt there is anything that I can say that will make this easier. Is it okay with you if I sit here with you for a few minutes?” Of the patient is unable or unwilling to answer, the practitioner can shift the focus to determining possible ways to be helpful (e.g. “How can I help you?”)
VALIDATE	Validate the other person’s experience. For example, “Given what you have just told me, it makes sense that you feel angry.
EXPLORE	Explore the next step/s. For example, “Who can I call to come and stay with you? or “This has been difficult for both of us. I am not sure where to go from here. Can I call you tomorrow to see how you are doing?”

Table 4 – SAVE the situation

encounters with patients. There needs to be adequate support and supervision provided and a recognition that the capacity to work through difficult situations is never constant, even for experienced practitioners. They should not ignore any distress or discomfort. Some practitioners may also be survivors of childhood sexual abuse themselves. Whilst some may be especially empathic towards other survivors, other may be at risk of being triggered, developing boundary problems and counter-transferring harmful responses to clients. Individuals should work through and come to terms with their own history of childhood sexual abuse to avoid confusing their own difficulties with those of their patients.

Supporting disclosure

The client's decision as to whether to disclose or not disclose a history of abuse should be respected. Qualitative research with survivors has identified a number of factors which might encourage disclosure⁷⁶. Survivors look for signals that the practitioner has an understanding of the effects of interpersonal violence, including posters and pamphlets (directed at both women and men), prominently displayed in waiting rooms, washrooms and meeting rooms. Survivors also stressed the importance of feeling safe and trusting their practitioners. They also needed to know about confidentiality and who else would the practitioner need to tell if they disclosed. There is no one correct way to ask about a history of childhood

abuse. Whilst some survivors may prefer direct approaches, for others these are too intrusive. Useful strategies include introducing questions in a way that relate past abuse to the current situation and care needs, so as to provide context and rationale. Statements similar to these may be useful:

"Some women and men want to talk to us about very personal or difficult topics. If you do, I am open to hearing about them."

Statements like this may open the door to disclosure, either in the moment or later on. If an individual hesitates or seems very reluctant to respond, a useful follow-up statement might be something like:

"I know these things can be hard to talk about. We think it is important to ask everyone because there is growing evidence that violence and abuse can affect a person's health and wellbeing. No one has to discuss anything that they don't want to. But if you do, I can work with you to ensure you are comfortable when you see me and to get whatever support or assistance you need."

It is crucial to respect a client's boundaries around disclosure and not to push for more information. Even if someone wants to disclose that they experienced abuse during their childhood, they may not want to discuss the details of their abuse with the practitioner. Communicating to survivors that they have been heard and believed is crucial. Table 5 lists the components of an effective response to disclosure (Schachter et al., 2008, p67⁷⁷).

It is crucial to respect a client's boundaries around disclosure and not to push for more information

After hearing a disclosure of past abuse, the clinician should:

- Accept the information
- Express empathy and caring
- Clarify confidentiality
- Normalize the experience by acknowledging the prevalence of abuse
- Validate the disclosure
- Address time limitations
- Offer reassurance to counter feelings of vulnerability
- Collaborate with the survivor to develop an immediate plan for self care

- Recognise that action is not always required
- Ask whether it is a first disclosure

At the time of disclosure or soon after:

- Discuss the implications of the abuse history for future health care and interactions with clinician
- Inquire about social support around abuse issues.

Table 5 – Components of an effective response to disclosure

The practitioner's immediate verbal and non-verbal responses to disclosure can have a huge impact on the survivor⁷⁸:

- Accept the information – the practitioner should show they have heard the information, accepted it and say they believe that children are never responsible for the abuse.
- Express empathy and caring – looking at the person and simple statements of concern can convey both compassion and interest, for example, "I'm really sorry this happened to you"
- Clarify confidentiality – tell the client whether you have to notify anyone else and ask them how they want the information recorded in their case notes.
- Acknowledge the prevalence of abuse – survivors can feel very isolated and alone in their experience. Providing information about the prevalence of abuse can be helpful, for example, "We know that as many as one in three women and one in seven men are survivors of childhood sexual abuse. It is sad to realize that so many children have suffered in this way."
- Validate the disclosure – the practitioner should validate the courage it took to disclose and communicate that they believe what they have been told. Visible distress needs to be acknowledged, for example "I see that this is painful for you right now. What can I do to help?"
- Address time limitations – if a client discloses a history of abuse and the practitioner can only spend a few minutes with them afterward, it is important that the time constraints are communicated in a way that will not leave survivors feeling dismissed or that they have done something wrong by disclosing.
- Offer reassurance – after disclosure clients may feel vulnerable and exposed. Practitioners should reassure them that they applaud their courage in talking about past abuse
- Collaborate to develop an immediate plan for self-care – practitioners may need to prepare clients that they may have unsettled feelings or flashbacks to their abuse as an immediate after-effect of disclosure. They should work to make a specific plan for self-care. For example, "Sometimes talking about past abuse stirs up upsetting memories, tell me what you can do to look after yourself if this happens to you."
- Recognise that action is not always required – the client may just want the practitioner to have the information and not necessarily expect the practitioner to do anything else except to be present with them in the moment. Not all survivors want or need to be referred to a mental health practitioner. By offering a referral before exploring the survivor's intentions, it may look like the

Verbal and non-verbal responses to disclosure can have a huge impact on the survivor

practitioner has judged the survivor to be “not okay”. It is important to first reinforce the acceptance of the survivor after the disclosure and explore the presence and effectiveness of supports (e.g. friends, family, counsellor etc.). This provides useful information about current resources and helps identify gaps. Raising the issue of referral to a mental health practitioner may be best postponed to a later interaction.

- Ask whether this is the patient’s first disclosure – this may help the practitioner get a sense of whether the survivor has previously taken any steps to address the abuse. It may also help them learn whether there were any previous poor responses to disclosure, what supports the clients have in place and what they may need.
- Use the information to support the client – over time the practitioner may seek to understand the survivor’s

reasons for disclosing and determine what (if anything) they want from the practitioner. For example, “Knowing this will help us to give you better support. Let me know what you need. I know that this abuse happened and if you need to talk about it or have any questions you can talk about them with me.” This may help the survivor express their needs or preferences.

The NHS Highland Council drew up guidelines for supporting adult survivors of CSA⁷⁹. They suggested that lengthy training is not necessary for dealing with initial disclosures, since this is about listening, not judging and finding out from the individual what they need from you. They recommended that training is required, however, for working with people on any severe to moderate mental health problems associated with CSA. They note that survivors of CSA say the most helpful worker:

Survivors have identified the following responses as clearly not helpful:

- Conveying pity (e.g. “Oh, you poor thing”).
- Offering simplistic advice (e.g. “Look on the bright side,” “Put it behind you,” “Get over it,” or “Don’t dwell on the past.”).
- Overstating or dwelling on the negative (“A thing like that can ruin your whole life”).
- Smiling (while you may hope that your smile conveys compassion, a neutral or concerned expression is more appropriate).
- Touching the person without permission even if you intend it as a soothing gesture.
- Interrupting (let the individual finish speaking).
- Minimizing or ignoring the individual’s experience of abuse, the potential impact of past abuse, or the decision

to disclose (e.g., “How bad could it be?”, “I know a woman that this happened to and she became an Olympic gold medallist,” “Let’s just concentrate on your back pain,” or “What’s that got to do with your sprained ankle?”).

- Asking intrusive questions that are not pertinent to the examination, procedure, or treatment.
- Disclosing your own history of abuse.
- Giving the impression that you know everything there is to know on the subject.
- If clinicians think that they have inadvertently responded to the disclosure in an inappropriate way, or if the patient’s non-verbal feedback suggests a negative reaction to their initial responses, they should immediately clarify the intended message and check with the survivor for further reaction.

Table 6 – Responses to avoid after a disclosure

- Is secure about boundaries, but relates with warmth and kindness.
- Is informed about CSA, or keen to learn.
- Has examined their own issues around CSA.
- Works non-hierarchically, consults clients, reaches joint decisions.
- Is client-centred, flexible and imaginative.
- Neither hides behind confidentiality, nor breaks it insensitively.
- Do my clients trust me enough to disclose? Are there any steps I could take to increase their feelings of trust and safety?
- How do I want talk supportively about child sexual abuse and respond if someone makes a disclosure? Do I have a ‘script’ that feels natural to me?
- How would I feel if a client disclosed a history of child sexual abuse? Are my reactions different for males and females? How would I know whether my reactions are helpful for my clients?

A list of responses to avoid after a disclosure is given in Table 6 (Schachter et al., 2008, p68⁸⁰).

Useful questions for staff to reflect on their own practice include⁸¹:

- Does my environment foster a sense of safety for potential disclosure?

Healthcare Improvement Scotland⁸² compiled a summary set of Do’s and Don’ts to help frontline practitioners who may be working with clients with a history of sexual abuse (Table 7). Although originally developed for professionals working with women during the perinatal period, these do’s and don’ts apply to other survivors of abuse as well.

DO

Be aware of the reality of child abuse

Know the potential symptoms which might be signals of an underlying CSA cause and address both symptoms and causes

Be aware that many survivors have practical as well as emotional problems that need to be dealt with so be prepared to help the “whole person”

Respond to distress rather than behaviours that may appear provocative

Adopt compassionate but firm professional boundaries around time, time contact and role

Be sensitive about and tackle the barriers that prevent people getting help

Remember that survivors have particular strengths and resilience that can be used in support work.

Help people disclose what has happened to them. Ask sympathetic, sensitive questions and always remember to ask

- “What problems, if any, do YOU think the abuse has left you with?”

- “What are the main things YOU would welcome help with now?”

Be prepared to refer survivors to other agencies for additional support

Aspire to have the qualities that survivors find most helpful

Do get sufficient training in listening and ensure you also get adequate support

DON’T

Be reluctant to raise the issue because of societal fears / stigma

Assume someone is a “difficult customer” if they are displaying fear, anger and hostility

Assume people will be alright if left as they are and that trying to help them will only make things worse

Assume that “one size fits all” – no one approach is superior

Diagnose or judge – your role is a listener

Table 7 – Do’s and don’ts for working with adult survivors

Common elements of effective interventions

Child sexual abuse (CSA) is often associated with more negative long-term outcomes than other forms of sexual victimisation. This is partly because CSA often involves repeated incidents. They also tend to use different services than survivors of adult sexual assault⁸³. Survivors of adult sexual assault appear to be more focused on their immediate crisis, justice and physical needs. They are likely to seek access to the criminal justice system and medical services. In contrast, adult survivors of CSA are more likely to use services that help with the longer-term psychological and interpersonal effects of their childhood experiences. These include social support/counselling-type services or face-to-face counselling.

There do not appear to be many proven interventions specifically developed for adults who had experienced childhood sexual abuse. 'Proven' means that they have been robustly evaluated to show that they are consistently effective in improving outcomes. Interventions may be described as promising when they have some evaluative evidence.

As well as interventions that have been developed specifically for this client group, adults who have experienced abuse will also benefit from interventions which have been developed for the general population (i.e. be non-abuse specific). There are several interventions which have been proven to be effective in improving poor mental health such as helping victims cope with trauma, or improving depression. As noted previously, a history of sexual abuse is associated with a lifetime diagnosis of anxiety, depression, eating disorders, PTSD, sleep disorders, and suicide attempts.

Kendall (2011⁸⁴) reviewed the available evidence on treatments for adult survivors of childhood sexual abuse. They concluded that abuse focused therapy such as CBT, EMDR and emotion-focused therapy was generally beneficial and yielded symptoms improvement, regardless of the specific therapeutic technique used.

Not everyone who has experienced childhood sexual abuse will show symptoms of poor mental health, trauma or post-traumatic stress disorder (PTSD) when they are adults. Some, however, will show these symptoms. For example some have estimated that 50% of CSA survivors experience PTSD compared to 8.7% of the general population⁸⁵. Not all survivors of trauma will have experienced sexual victimization or childhood abuse – this client group shows great diversity in experiences. Trauma also includes physical abuse, neglect, domestic violence, community violence, war or natural disasters.

Ehring et al. (2014⁸⁶) carried out a meta-analysis of all the evidence relating to psychological treatments for post-traumatic stress disorder in adult survivors of childhood abuse. They identified sixteen robust randomized control trial evaluations that could be subdivided into trauma-focused cognitive behaviour therapy (CBT), non-trauma-focused CBT, eye movement desensitization and reprocessing, and other treatments (interpersonal, emotion-focused). Results showed that psychological interventions are effective for PTSD in adult survivors of childhood abuse. Trauma-focused treatments were more effective than non-trauma focused interventions and treatments including individual sessions showed greater improvements in client outcomes than pure group treatments. They concluded that the best effects can be achieved with individual trauma-focused treatments.

Interventions shown to be effective for PTSD following childhood maltreatment and other traumas

Several interventions have been shown to be particularly effective in treating clients who have experienced a range of traumas. There has been some debate as to whether evidence based interventions originally developed for PTSD following adult-onset trauma are also effective with adult survivors of child-onset trauma, or whether interventions specifically tailored for this group are needed. There

There are few proven interventions specifically developed for adults who had experienced childhood sexual abuse

Survivors of childhood abuse tend to show high levels of symptom complexity beyond PTSD

is extensive evidence that survivors of childhood abuse tend to show high levels of symptom complexity beyond PTSD, including emotion regulation difficulties, interpersonal problems, impulsive and/or self-destructive behaviour, and high levels of dissociation, substance-related problems, or somatic symptoms⁸⁷.

Ehring et al. (2014) summarized that there are three main approaches or 'schools of thought' to using trauma focused interventions with childhood abuse survivors:

1. A number of authors propose that trauma-focused treatments originally developed for survivors of adult-onset trauma can also be offered to the childhood abuse survivor group without any major modifications. Examples for trauma-focused interventions that have been offered to childhood abuse survivors are prolonged exposure treatment, trauma-focused cognitive-behaviour therapy (TF-CBT) involving exposure interventions plus cognitive restructuring, cognitive processing therapy, or EMDR.
2. Some suggest that interventions for childhood abuse survivors with PTSD should be trauma-focused, but adapted for the specific needs of
3. The third group of authors argue that trauma-focused treatments may not be suitable for clients with PTSD following childhood abuse as emotion regulation difficulties or other aspects of symptom complexity often found in this group may lead to symptom exacerbation when patients are systematically exposed to aspects of the trauma memory. Following this view, a number of non-trauma-focused treatments have been developed focusing exclusively on safety, coping, anxiety management or related issues. This group of interventions is very heterogeneous and includes treatments based on principles of cognitive behaviour therapy or interpersonal treatments.



Ehring et al. (2014) examined all the published evidence relating to the effectiveness of psychological treatments for post-traumatic stress disorder in adult survivors of childhood sexual and/or physical abuse. Their meta-analysis showed that:

- trauma-focused treatments performed significantly better for adults who had experienced childhood maltreatment than non-focused treatment. The best evidence currently exists for trauma-focused cognitive-behavioural therapy (TF-CBT). Eye movement desensitization and reprocessing (EMDR) has also been shown to be effective. Both of these can be classified as trauma-focused treatments because they mainly focus on processing the memory of the trauma and/or its meaning.
- The authors suggested that from a theoretical perspective, it seems plausible that the efficacy of PTSD treatments is related to the degree to which the treatment helps the individual to process the memory of the traumatic event. They also suggested that these findings do not support concerns that it is not safe to use trauma-focused treatments in individuals suffering from high levels of symptom complexity. There were also similar levels of drop-out from trauma and non-trauma focused interventions.
- Both trauma-focused and non-trauma focused were better at effective at improving client outcomes when compared with no treatment. Individuals who received either type of treatment showed significantly improved depression, anxiety and dissociation compared to those who received no treatment.
- Interventions that included individual treatment sessions showed significantly larger improvements than pure group treatments.

- A similar pattern of results was found irrespective of whether only randomized control trials were included, and also when all other evidence such as non-randomised and uncontrolled evaluations were included.
- The authors concluded that the meta-analysis supports the current treatment guidelines recommending individual trauma-focused treatments as first-line interventions. The findings show that the guidelines are also valid for this group of trauma survivors who had experienced childhood abuse.
- They also highlighted that variations between trauma-focused interventions are beginning to be better understood. For example, there is emerging evidence that a phase-based approach comprising skills training and trauma-focused interventions is more effective than trauma-focused treatment alone.

The California based evidence Clearing House for Child Welfare reviewed the evidence base for interventions that are effective at improving outcomes for people who have experienced trauma amongst individuals who were receiving child welfare services or who are similar to child welfare populations. We examined all the programmes in their database that they have rated for suitability specifically for adult survivors of abuse, or for treatments for common effects of maltreatment shown by adult survivors (such as depression, trauma treatment including PTSD). The Clearing house rates programmes for their level of relevance to child welfare populations:

- High – The program was designed, or is commonly used, to meet the needs of children, youth, young adults, and/or families receiving child welfare services.
- Medium – The program was designed, or is commonly used, to serve children, youth, young adults, and/or families who are similar to child

Trauma-focused treatments performed significantly better than non-focused treatment

Mindfulness approaches have been shown to be effective

welfare populations (i.e., in history, demographics, or presenting problems) and likely include current and former child welfare services recipients.

- Low – The program was designed, or is commonly used, to serve children, youth, young adults, and/or families with little or no apparent similarity to the child welfare services population.

Several programmes were identified as having good evidence base. Only programmes which had Evidence ratings Levels 1 or 2 are included in the table, and which are also described as being of high or medium relevance to child welfare populations.

A short overview of the common characteristics of these effective programmes is provided below, and more detail on each programme is given in Appendix 1. Links are provided in Appendix 1 to sources of further information about implementation and training requirements for each of the programmes.

Similar to the findings noted in Ehring et al.'s (2014) meta-analysis above, many of the effective programmes identified by the Clearing House use a cognitive approach where the client is supported to change their thinking patterns to the traumatic events and learn new coping styles. Cognitive approaches can be delivered either one-to-one or group sessions, and often include homework activities.

Mindfulness approaches have also been shown to be effective. These differ from cognitive approaches in that they focus on helping clients cope in their current situations, and no focus is placed on what

the original events were that may have led to the poor mental health or distress. These may be particularly useful approaches for situations where it is not clear whether a client has experienced childhood maltreatment, or where the client is not ready to take part in describing what happened during their childhood.

One approach which has been developed for clients who have experienced sexual trauma (including both childhood trauma and adult sexual trauma), is Helping Women Recover and Beyond Trauma (HWR/BT). It is a structured approach which helps women who have addiction problems as well as a history of trauma. The evidence for this approach shows that it is promising.

In 2007, Russell & Davis⁸⁸ reviewed the empirical research on treatment following sexual assault (they did not differentiate as to whether the sexual assault had occurred during childhood or adulthood). They recommended that given the strength of accumulated evidence, rape crisis centres and social workers would be well advised to consider exposure and cognitive behavioural interventions when presented with a rape survivor.

In 2014 Wilen⁸⁹ undertook a meta-analysis of psychosocial interventions for adults who were sexually abused as children. They reviewed over 17,000 studies and concluded that psychosocial treatment was more effective than no treatment for PTSD, depression, anxiety and dissociation. They concluded that trauma-centred approaches may work best for PTSD symptoms while more present-focused approaches may be more effective for depression.

Summary

Supporting the client to feel safe and in control of what happens to them is key to success. Training and providing ongoing support to practitioners is also important.

It can be useful to provide accurate information to clients about the nature of trauma and its effects, and work with them to integrate what they have learnt into their overall perspective.

Clients should be taught adaptive coping strategies such as self-care, distress tolerance strategies and arousal reduction strategies.

Approaches which involve monitoring thoughts and responses and work to change emotions, thoughts and behaviours can be particularly effective (even if they are non-trauma focused). It can also be useful to teach clients interpersonal and assertiveness skills.

Adapt the therapy to the client, rather than expecting the client to adapt to the therapy. This is easiest when practitioners are trained in several different treatment approaches to allow tailoring to the needs and preferences of the client.





SENSITIVE PRACTICE

Services should develop principles of sensitive practice as a way of working with all clients. Adopting these may involve training, ongoing supervision and support from management, and potential changes to some procedures.

In developing a new service approach, the views and insights of survivors and practitioners should be sought throughout the development of the model, so that support can be provided in the most effective way possible. This should be done through a process of co-production, where everyone's views (whether professional and/or personal) are seen as equally important and valid.

Once the service is being implemented, evidence should be gathered around how well it is working from the perspectives of clients and staff, as well as what difference it is making to survivors' lives. This evidence should be regularly reviewed and the learning used to improve service delivery.

All staff who come into contact with clients should receive basic training in sensitive

practice and communicating with clients in a supportive way.

Multiple 'signals' should convey the message to clients that the team is knowledgeable and open to supporting individuals with abuse histories. These can include displaying printed materials (e.g. posters, leaflets) that refer to the support available for survivors of CSA and which take account of diversity (such as different genders, ages and ethnic groups) in the imagery used. Practitioners could also routinely mention the availability of support to all clients.

Practitioners should receive training in:

- the long-term effects of CSA and some of the difficulties that adult survivors may experience.

- how to examine their own preconceptions about CSA.
- practical training in how to handle disclosures.
- how to support clients who have experienced trauma, e.g. managing emotions such as transference and anger, and disassociation.

Practitioners should receive ongoing support in their work including opportunities for peer support, reflection on practice and regular supervision.

Clients should be treated with respect and empathy. They should be supported to feel safe and in control of what is happening to them.

There should be flexibility in the service to accommodate different clients' preferences and needs. The client should be actively involved in deciding what service will best meet their needs and their cultural perspective taken into account. There should be a range of appointment times offered, including short-notice appointments. Clients who repeatedly miss appointments can be helped by developing a support plan with them.

Clients should be provided with the opportunity to disclose if they want to. It is crucial to respect a client's boundaries around disclosure and not to push for more information. Communicating to survivors that they have been heard and believed is crucial. It should be recognised that even after disclosure, not everyone will want or need further support.

It should be recognised that healing is not a linear process and ongoing support may be required either continually or intermittently for some time.

Clients should be supported to develop core skills. These may include skills such as decision-making, building self-esteem, assertiveness, safety, asking for help,

setting boundaries in relationships, healthy relationships, community resources, compassion, creating meaning, discovery, recovery thinking, taking good care of yourself, commitment, coping with triggers, self-nurturing, Red and Green Flags, and life choices.

It can be useful to provide accurate information to clients about the nature of trauma and its effects, and work with them to integrate what they have learnt into their overall perspective. Possible topics could include Self, Relationships, Sexuality, and Spirituality; Violence, Abuse, and Trauma; The Impact of Trauma on Women's Lives; and Healing from Trauma.

Approaches which involve monitoring thoughts and responses and work to change emotions, thoughts and behaviours can be particularly effective (even if they are non-trauma focused). It can also be useful to teach clients interpersonal and assertiveness skills.

Clients should be taught adaptive coping strategies such as self-care, distress tolerance strategies and arousal reduction strategies. It is not enough to help survivors get rid of maladaptive or poor coping strategies – these must be replaced with positive and healthier ways of coping.

Clear referral pathways should be established so survivors can receive other more intensive therapeutic supports if they need and want them. The interventions that have been shown to be most effective tend to use cognitive-behavioural therapy, EMDR or mindfulness approaches. Both trauma focused, and non-trauma focused interventions can help clients. Group approaches can be effective, but they are most effective if combined with individual support. They need to be delivered by experienced professionals who ideally can work across a number of models to provide choice and flexibility to the client.

There should be flexibility in the service to accommodate different clients' preferences and needs



APPENDIX

Appendix 1 Evidence base for treatments which may be relevant to adult survivors of abuse

Evidence rating from the Clearing House (more details on <http://www.cebc4cw.org/ratings/scientific-rating-scale/>)

1. Well supported by research evidence
2. Supported by research evidence
3. Promising research evidence
4. Evidence fails to demonstrate effect
5. Concerning practice.

Programme	Target population	Approach	Style of delivery	Evidence rating	More information
Acceptance and Commitment Therapy (ACT)	Adults with depression. Also used with adults with a variety of other mental health disorders and behavioural problems.	A contextually focused form of cognitive behavioural psychotherapy that uses mindfulness and behavioural activation to increase a client's psychological flexibility—his/her ability to engage in values-based, positive behaviours while experiencing difficult thoughts, emotions, or sensations. Desired outcomes are: <ul style="list-style-type: none"> • Reduced psychopathology • Increased work performance • Increased physical health • Increased quality of life 	One-on-one sessions, in small groups or larger workshops, or in books or other media, through the presentation of information, dialogue, and the use of metaphors, visualization exercises, and behavioural homework	Well supported by research evidence (level 1) Relevance Medium	http://www.cebc4cw.org/program/acceptance-and-commitment-therapy/ detailed
Adult-Focused Family Behaviour Therapy (Adult-Focused FBT)	Adults with drug abuse and dependence, as well as other co-existing problems such as depression, family dysfunction, trauma, child maltreatment, non-compliance, employment, HIV/STIs risk behaviour, and poor communication skills	Adult-Focused FBT is designed to be used with adults, multiple ethnicities, differing types of substance abuse (alcohol, marijuana, and hard drugs), and across genders. The overall goals of Adult-Focused Family Behaviour Therapy are: <ul style="list-style-type: none"> • Decrease alcohol and drug use • Decrease depression • Decrease conduct problems • Decrease family dysfunction • Decrease days absent from work/school • Decrease child abuse potential • Decrease HIV Risk Behaviours 	Adult-Focused FBT includes more than a dozen treatments including management of emergencies, treatment planning, home safety tours, behavioural goals and rewards, contingency management skills training, communication skills training, child management skills training, job-getting skills training, financial management, self-control, environmental control, home safety and aesthetics tours, and tele-therapy to improve session attendance. Therapies are consumer-driven and culturally sensitive.	Supported by research evidence (level 2) Relevance High	http://www.cebc4cw.org/program/adult-focused-family-behavior-therapy/ detailed

Cognitive Processing Therapy (CPT)	Adults who have experienced a traumatic event and are currently suffering from the symptoms of post-traumatic stress disorder (PTSD) and/or meet criteria for a diagnosis of PTSD or are currently diagnosed with PTSD (originally developed for use with rape and crime victims)	Goals of Cognitive Processing Therapy (CPT) are: <ul style="list-style-type: none"> • Advance the client's understanding of post-traumatic stress disorder (PTSD) and how it affects their life • Reduce the client's distress about their memories of the trauma • Decrease the client's emotional numbing and avoidance and increase helpful coping • Reduce feelings of being tense or "on edge" • Decrease the client's depression, anxiety, guilt/shame, or anger • Improve the client's day-to-day living 	Essential components include: <ul style="list-style-type: none"> • Leading clients to understand their reasoning processes and belief through Socratic Questioning • Assisting the client to identify and evaluate unhelpful thoughts through structured therapy sessions and learning skills • Educating the client on common reactions to trauma • Assigning the client regular out-of-session practice assignments to learn and apply what has been discussed in therapy • Teaching the client skills to manage thoughts and beliefs • CPT is delivered one-on-one or in a group led by two clinicians and a limit of 8 to 10 patients. 	Well supported by research evidence (level 1) Relevance Medium	http://www.cebc4cw.org/program/cognitive-processing-therapy-cpt/ detailed
Cognitive Therapy (CT)	Adults with mental health disorders including depression, anger, and anxiety among others – the program is also designed to include family members in the treatment	Cognitive Therapy (CT) is a form of psychotherapy. The therapist and client work together as a team to identify and solve problems. Therapists help clients to overcome their difficulties by changing their thinking, behaviour, and emotional responses.	Can be administered individually or in a group of 8-12 participants Recommended Intensity: 50-minute weekly sessions Recommended Duration: 12 weeks average	Well supported by research evidence (level 1) Relevance Medium	http://www.cebc4cw.org/program/cognitive-therapy/ detailed
Eye Movement Desensitization and Reprocessing for Adults (EMDR)	Adults who have experienced trauma and may experience post-traumatic stress disorder (PTSD), post-traumatic stress, phobias, and other mental health disorders	EMDR therapy is an 8-phase psychotherapy treatment that was originally designed to alleviate the symptoms of trauma. The overall goals are: <ul style="list-style-type: none"> • Target the past events that trigger disturbance • Target the current situations that trigger disturbance • Determine the skills and education needed for future functioning • Reduce subjective distress • Strengthen positive beliefs • Eliminate negative physical responses • Promote learning and integration so that the trauma memory is changed to a source of resilience 	During the EMDR trauma processing phases, guided by standardized procedures, the client attends to emotionally disturbing material in brief sequential doses that include the client's beliefs, emotions, and body sensations associated with the traumatic event while simultaneously focusing on an external stimulus. Therapist directed bilateral eye movements are the most commonly used external stimulus, but a variety of other stimuli including hand-tapping and audio bilateral stimulation are often used	Well supported by research evidence (level 1) Relevance Medium	http://www.cebc4cw.org/program/eye-movement-desensitization-and-reprocessing-for-adults/ detailed

Helping Women Recover & Beyond Trauma (HWR/BT)	Adult women with addictive disorders and a trauma history (e.g., abuse, domestic violence, community violence, etc.)	The overall goals of Helping Women Recover & Beyond Trauma (HWR/BT) are to accomplish are: <ul style="list-style-type: none"> • Decrease in substance abuse • Decrease in depression • Increase in understanding of trauma • Decrease in trauma symptoms • Increase in self-efficacy • Stabilized recovery 	HWR/BT is a 28-session intervention that integrates three theories: a theory of addiction, a theory of women's psychological development, and a theory of trauma; and then adds a psychoeducational component that teaches women what trauma is, its process, and its impact. The program model is organized into seven modules. The first four: Self, Relationships, Sexuality, and Spirituality are areas that recovering women have identified as triggers for relapse and as necessary for growth and healing. The last three: Violence, Abuse, and Trauma; The Impact of Trauma on Women's Lives; and Healing from Trauma; focus on the trauma with a major emphasis on coping skills, with specific exercises for developing emotional wellness. The program comes with facilitator's manuals, two participant workbooks (A Women's Journal and A Healing Journey), and 3 DVDs. The materials are designed to be user-friendly and self-instructive. A special edition for criminal justice settings has also been developed.	Supported by research evidence (level 2) Relevance Medium	http://www.cebc4cw.org/program/helping-women-recover-beyond-trauma-hwr-bt/detaile
Interpersonal Psychotherapy (IPT)	Adults with depression. Can be adapted for depressed adolescents, geriatric patients, pregnant, and postpartum depressed woman	IPT is based on the idea that the symptoms of depression have multiple causes. The onset of depressive symptoms is usually associated with a trigger in the patient's current personal life. IPT helps the patient to identify and learn how to deal with those personal problems and to understand their relationship to the onset of symptoms. The essential components include: <ul style="list-style-type: none"> • Taking a time-limited and manualized approach • initial diagnostic evaluation • Relates the onset of symptoms to a problem area such as grief, disputes, transitions, and role deficits • developing skills for coping with and relieving depression • Using standard techniques (e.g., clarification, role play, decision analysis), but focusing on the here-and-now problems in relationship to the onset of symptoms • Using an interpersonal inventory conducted by the therapist to determine important people, both supportive and not, in the patient's life • Being a medical model 	There are three phases: <ul style="list-style-type: none"> • The diagnostic and problem identification phase where a formulation and treatment contract are made • Identification of the problem area(s): grief, disputes, transition, or deficits, which is the focus of the middle phase • Termination • Can be used in individual or group treatment. Recommended group size is 12-15 participants 	Well supported by research evidence (level 1) Relevance Medium	http://www.cebc4cw.org/program/interpersonal-psychotherapy/detailed

Intensive Short-Term Dynamic Psychotherapy (ISTDP)	Adults with a broad range of disorders including personality disorders. This treatment and variants of it have been extensively researched and shown effective with some patients with depression, anxiety, somatization, substance abuse, eating disorders and personality problems.	The basic ISTDP understanding of many psychological disorders is based on attachment and the emotional effects of broken attachments. Interruptions and trauma to human attachments may cause a cascade of complex emotions which may become blocked and avoided. When later life events stir up these feelings, anxiety and emotional defences may be activated. These reactions may be totally unconscious to the person having them, and the result is ruined relationships, physical symptoms, and a range of psychiatric symptoms. A proportion of all patients with anxiety, depression, substance use, and interpersonal problems have this emotional blockage problem. ISTDP focuses on emotional awareness and the ability to feel these emotions in order to heal. The overall goal is resolution of attachment trauma-related symptoms that manifest as anxiety, depression, conduct problems, and somatic symptoms	ISTP steps are: <ul style="list-style-type: none"> • To acquaint the patient with the unconscious processes that they use to deal with difficult situations • To help them to overcome the emotional blocking processes. This often means a focus on the feelings the patient has in the office during the moments of the interview and pointing out the ways the patient blocks off both the emotions and the connection with the therapist. • When these feelings are experienced there is an abrupt drop in tension, anxiety and other physical symptoms and defences. Thus, the patient and therapist can then see the driving emotional forces that were being defended. Thereafter, a healing process may occur in which the old avoided feelings are experienced and worked through. If the patient has very low tolerance of anxiety, a treatment process in group or individual therapy may be required first to build this up before the emotions can be experienced • At the end of a successful therapy, there is an absence of somatic anxiety and major defences. 	Supported by research evidence (level 2) Relevance Medium	http://www.cebc4cw.org/program/intensive-short-term-dynamic-psychotherapy/detailed
Interpersonal Psychotherapy (IPT)	Adults with depression	IPT is a time-limited and manual-specified psychotherapy developed initially for patients with major depressive disorder, but later adapted for other disorders and tested in numerous clinical trials. Designed for administration by trained mental health professionals, it can also be taught, with adaptations, to less trained health workers. IPT has been used with and without medication. IPT is based on the idea that the symptoms of depression have multiple causes. The onset of depressive symptoms is usually associated with a trigger in the patient's current personal life.	IPT helps the patient to identify and learn how to deal with personal problems and to understand their relationship to the onset of symptoms. There are three phases: <ul style="list-style-type: none"> • The diagnostic and problem identification phase where a formulation and treatment contract are made • Identification of the problem area(s): grief, disputes, transition, or deficits, which is the focus of the middle phase • Termination 	Well supported by research evidence (level 1) Relevance Medium	http://www.cebc4cw.org/program/interpersonal-psychotherapy/detailed

Mindfulness-Based Cognitive Therapy (MBCT)	Adults (between 18-70 years old) who have suffered three or more prior episodes of major depression	<p>MBCT includes simple meditation techniques to help participants become more aware of their experience in the present moment, by tuning in to moment-to-moment changes in the mind and the body. The overall goals are:</p> <ul style="list-style-type: none"> • Target the critical risk mechanism in recurrent depression: patients' tendency to react to small changes in mood with large amounts of negative self-focused rumination • Teach patients (in groups and through home-based practice) to notice the tendency to ruminate earlier in its sequence so that more skillful means can be deployed in responding (rather than reacting) to whatever is causing it • Teach participants to recognize the mode of mind they are in, so they can, if they choose, change from analytic (over-thinking) mode to a mindful, experiential mode 	<p>Participants learn the practice of mindfulness meditation through a course of eight weekly classes (the atmosphere is that of a class, rather than a therapy group) and through daily practice of meditation skills while listening to tapes at home. MBCT also includes basic education about depression and suicidality, and a number of exercises derived from cognitive therapy. These exercises demonstrate the links between thinking and feeling and demonstrate ways that participants can care for themselves when they notice their mood changing or a crisis threatens to overwhelm them. Essential components of) include:</p> <ul style="list-style-type: none"> • Makes no attempt to change the content of negative thinking, unlike Cognitive Therapy • Encourages participants to change their relationship to their own thoughts, feelings, and body sensations, so that they have an opportunity to discover that these are fleeting events in the mind and the body which they can choose to engage with – or not • Helps participants to realize that their thoughts, emotions, and sensations are just thoughts, emotions, and sensations, rather than 'truth' or 'me' by having the therapist repeatedly notice and observe with interest and compassion • Helps participant learn to see more clearly the patterns of the mind, and to recognize when his/her mood is beginning to dip without adding to the problem by falling into analysis and rumination • Helps break the old association between negative mood and the negative thinking • Helps participants develop the capacity to allow distressing emotions, thoughts, and sensations to come and go, without feeling that they have to suppress them, run away from them, or do battle with them • Strives to have participants learn to stay in touch with the present moment, without being driven to dwell on the past or worry about the future • Taught in classes with the recommended size being 12 participants 	Well supported by research evidence (level 1) Relevance Medium	http://www.cebc4cw.org/program/mindfulness-based-cognitive-therapy/detailed
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Prolonged Exposure Therapy for PTSD for Adults (PE)	Adults with a variety of traumas such as combat, sexual assault, car accidents, violent crimes, and acts of terrorism	<p>The overall goal of Prolonged Exposure (PE) to promote the clients' ability to emotionally process their traumatic experiences and consequently diminish PTSD and other trauma-related symptoms. The essential components of Prolonged Exposure (PE) include:</p> <ul style="list-style-type: none"> • Delivering rationales for the treatment program, as well as for the in vivo and imaginal exposure, to the client in order to increase understanding of the treatment components and how they will help diminish PTSD symptoms. • Creating an in vivo exposure hierarchy together with the client and guiding the client in implementing in vivo exposures to trauma reminders and situations that feel unsafe as a result of the trauma • Conducting repeated and prolonged imaginal exposure to the trauma memory with the client, where the client is asked to recall and retell the trauma memory • Delivering psychoeducation regarding common reactions to trauma • Teaching breathing/retraining exercise that can help patients to feel more calm 	<p>PE consists of 8–15 weekly or semi-weekly treatment sessions that are 60-90 minutes each. Clients are encouraged to repeatedly approach situations or activities they are avoiding because they remind them of their trauma (in vivo exposure) as well as to revisit the traumatic memory several times through retelling it (imaginal exposure). Psychoeducation about common reactions to trauma as well as breathing retraining exercises are also included in the treatment. The aim of in vivo and imaginal exposure is to help clients emotionally process their traumatic memories through imaginal and in vivo exposure. Through these procedures, they learn that they can safely remember the trauma and experience trauma reminders, that the distress that initially results from confrontations with these reminders decreases over time, and that they are capable of tolerating this distress.</p>	Well supported by research evidence (level 1) Relevance Medium	http://www.cebc4cw.org/program/prolonged-exposure-therapy-for-adults-pe-for-ptsd/detailed
Seeking Safety for Adults	Adults who have a history of trauma and/or substance abuse	<p>The primary goals of Seeking Safety for Adults are:</p> <ul style="list-style-type: none"> • Reduce trauma and/or substance abuse symptoms • Increase safe coping in their relationships • Increase safe coping in their thinking • Increase safe coping in their behaviour • Increase safe coping in their emotions 	<p>Seeking Safety is a present-focused, coping skills therapy to help people attain safety from trauma and/or substance abuse. The treatment is available as a book, providing both client handouts and clinician guidelines. The treatment may be conducted in group or individual format; with females and males; and in various settings (e.g. outpatient, inpatient, residential, home care, schools). Seeking Safety consists of 25 topics that can be conducted in as many sessions as time allows, and in any order. Examples of topics are Safety, Asking for Help, Setting Boundaries in Relationships, Healthy Relationships, Community Resources, Compassion, Creating Meaning, Discovery, Recovery Thinking, Taking Good Care of Yourself, Commitment, Coping with Triggers, Self-Nurturing, Red and Green Flags, and Life Choices.</p>	Supported by research evidence (level 2) Relevance Medium	http://www.cebc4cw.org/program/seeking-safety-for-adults/detailed

<p>Trauma Recovery and Empowerment Model (TREM)</p>	<p>Women who have a history of sexual, physical, and/or emotional abuse and can have severe mental health problems and frequent co-occurring substance abuse issues</p>	<p>TREM is a fully manualized group intervention for women who survived trauma and have substance use and/or mental health conditions. This model draws on cognitive-behavioural, skills training, and psychoeducational techniques to address recovery and healing from sexual, physical, and emotional abuse.</p> <p>Overall goals are:</p> <ul style="list-style-type: none"> • Increased trauma recovery skills • Increased self-esteem • Increased boundary-setting • Increased emotional regulation • Increased judgment and decision-making • Decreased mental health symptoms • Decreased anxiety • Decreased depression • Decreased hostility • Decreased post-traumatic stress disorder (PTSD) symptoms • Decreased substance abuse 	<p>TREM is a fully manualized 24- to 29-session group intervention. TREM consists of three major parts.</p> <ul style="list-style-type: none"> • empowerment helps group members learn strategies for self-comfort and accurate self-monitoring as well as ways to establish safe physical and emotional boundaries. • More direct focus on trauma experience and its consequences. • focus then shifts explicitly to skills building. • These sessions include emphases on communication style, decision-making, regulating overwhelming feelings, and establishing safer, more reciprocal relationships. 	<p>Promising research evidence (level 3)</p> <p>Relevance Medium</p>	<p>http://www.cebc4cw.org/program/trauma-recovery-and-empowerment-model/ detailed</p>
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